Aetna HealthFund® CDHP / Aetna Value Plan

http://www.aetnafeds.com
Customer service 1-888-238-6240

2016

An individual practice plan with a consumer driven health plan (CDHP) option and a value plan option

Serving: In all 50 states and the District of Columbia

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 4 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 21
- Summary of benefits: Page 152

Underwritten and administered by: Aetna Life Insurance Company

Enrollment in this Plan is limited: You must live or work in our geographic service area to enroll. See pages 16-20 for requirements.

Enrollment code for: CT, DE, MA, ME, NH, NJ, NY, RI, VT

EP1 CDHP - Self Only	**EP4 Value Plan - Self Only**
EP3 CDHP - Self Plus One	**EP6 Value Plan - Self Plus One**
EP2 CDHP - Self and Family	**EP5 Value Plan - Self and Family**

Enrollment code for: ID, IL, IA, KY, MN, MS, MT, ND, NE, OR, PA, WY

H41 CDHP - Self Only	**H44 Value Plan - Self Only**
H43 CDHP - Self Plus One	**H46 Value Plan - Self Plus One**
H42 CDHP - Self and Family	**H45 Value Plan - Self and Family**

Enrollment code for: AK, CA, HI, IN, OH, OK, SC, TX, WI

JS1 CDHP - Self Only	**JS4 Value Plan - Self Only**
JS3 CDHP - Self Plus One	**JS6 Value Plan - Self Plus One**
JS2 CDHP - Self and Family	**JS5 Value Plan - Self and Family**

Enrollment code for: AL, AR, DC, FL, GA, LA, MD, NC, TN, VA, WV

F51 CDHP - Self Only	**F54 Value Plan - Self Only**
F53 CDHP - Self Plus One	**F56 Value Plan - Self Plus One**
F52 CDHP - Self and Family	**F55 Value Plan - Self and Family**

Enrollment code for: AZ, CO, KS, MI, MO, NV, NM, SD, UT, WA

G51 CDHP - Self Only	**G54 Value Plan - Self Only**
G53 CDHP - Self Plus One	**G56 Value Plan - Self Plus One**
G52 CDHP - Self and Family	**G55 Value Plan - Self and Family**

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Aetna About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that Aetna prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800/772-1213 (TTY: 1-800/325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help.
- Call 1-800-MEDICARE (1-800/633-4227), TTY: (1-877/486-2048).

Table of Contents

Introduction

This brochure describes the benefits you can receive of Aetna Life Insurance Company under our contract (CS 2938) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-888/238-6240 or through our website: www.aetnafeds.com. The address for the Aetna* administrative office is:

Aetna Life Insurance Company
Federal Plans
PO Box 550
Blue Bell, PA 19422-0550

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefits are effective January 1, 2016, and changes are summarized on page 21. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) 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/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

**Health benefits and health insurance plans are offered, underwritten or administered by Aetna Life Insurance Company*

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Aetna.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-888-238-6240 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
877-499-7295
OR go to:

www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**
   - Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
   - Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
   - Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
   - Make sure your medicine is what the doctor ordered. Ask the pharmacist about the medication if it looks different than you expected.
   - Read the label and patient package insert when you get your medicine, including all warnings and instructions.
   - Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
   - Contact your doctor or pharmacist if you have any questions.

3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures.
   - Don’t assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
   - Call your doctor and ask for your results.
   - Ask what the results mean for your care.

4. **Talk to your doctor about which hospital is best for your health needs.**
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, “Who will manage my care when I am in the hospital?”
   - Ask your surgeon:
     - "Exactly what will you be doing?"
     - "About how long will it take?"
     - "What will happen after surgery?"
     - "How can I expect to feel during recovery?"
   - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures, and to reduce medical errors that should never happen. These conditions and errors are called "Never Events." When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you use Aetna preferred providers. This new policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

  We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) 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/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard (MVS)**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - When the next Open Season for enrollment begins

  We don’t determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event.

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self Plus One or Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2016 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2015 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

  You will receive an additional 31 days of coverage, for no additional premium, when:

  - Your enrollment ends, unless you cancel your enrollment; or
  - You are a family member no longer eligible for coverage.

  Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

- **Upon divorce**

  If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at: http://www.opm.gov/healthcare-insurance/healthcare/plan-information/.

- **Temporary Continuation of Coverage (TCC)**

  If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc. You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

  Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Finding replacement coverage**

  In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 1-888/238-6240 or visit our website at www.aetnafeds.com.

- **Health Insurance Marketplace**

  If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is an individual practice plan offering you a choice of a Consumer Driven Health Plan (CDHP) or a Value Plan.

General features of our Consumer Driven Health Plan (CDHP)

Our CDHP is a comprehensive consumer driven health plan that combines a traditional health plan with separate medical and dental funds that help you pay for covered medical and dental expenses. Aetna's CDHP puts you first, can save you time and money, and gives you flexibility, choice and control.

For 2016, CDHP offers 100% in-network preventive care coverage, including dental. You have:

- A consumer-controlled annual Medical Fund of $1,000/Self Only, $2,000/Self Plus One, or $2,000/Self and Family and an annual Dental Fund of $300/Self Only $600/Self Plus One, or $600/Self and Family to help you pay for eligible expenses. You use your Medical Fund first for covered medical expenses, then you need to satisfy your annual deductible. Once your deductible has been satisfied, the Traditional Medical Plan benefits will apply.
- Opportunity to rollover unused Medical and Dental Funds for use in future years.
- Online tools to help you manage your money and your health.
- Freedom to choose the providers you wish to see – with no referrals.
- A cap that limits the total amount you pay annually for eligible expenses.

Preventive care services for your CDHP

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Deductible for your CDHP

Once you have exhausted your medical fund, the annual deductible of $1,000 for Self Only, $2,000 for Self Plus One and $2,000 for Self and Family must be met before Traditional Medical Plan benefits are paid for care other than preventive care services.

Catastrophic protection for your CDHP

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and coinsurance cannot exceed $4,000 for Self Only enrollment, $6,850 for Self Plus One enrollment or $6,850 for Self and Family enrollment for in-network services or $5,000 for Self Only enrollment, $10,000 for Self Plus One enrollment or $10,000 for Self and Family enrollment for out-of-network services. The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%.

General features of our Value Plan

Our Value Plan is a comprehensive medical plan. You can see participating or nonparticipating providers without a referral. You also can earn health incentive credits to reduce your out of pocket medical costs (deductible and medical coinsurance).

Preventive care services for your Value Plan

Preventive care services are generally paid as first dollar coverage and are not subject to copayments, deductibles, or annual limits when received from a network provider.

Annual deductible for your Value Plan

The annual deductible of $600 for Self Only, $1,200 for Self Plus One, or $1,200 for Self and Family in-network and $1,250 for Self Only, $2,500 for Self Plus One, or $2,500 for Self and Family out-of-network, must be met before Plan benefits are paid for care other than preventive care services, PCP or Specialist office visits and prescription drugs.

Catastrophic protection for your Value Plan

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles, coinsurance and copayments cannot exceed $5,000 for Self Only enrollment, $6,850 for Self Plus One enrollment, or $6,850 for Self and Family enrollment for in-network services or $5,000 for Self Only enrollment, $10,000 for Self Plus One enrollment, or $10,000 for Self and Family enrollment for out-of-network services. The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%.

Health education resources and accounts management tools

We have online, interactive health and benefits information tools to help you make more informed health decisions. (See pages 36 and 84).

We have Network Providers

Our network providers offer services through our Plan. When you use our network providers, you will receive covered services at reduced costs. In-network benefits apply only when you use a network provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. Aetna is solely responsible for the selection of network providers in your area. You can access network providers on DocFind by visiting our website at www.aetnafeds.com, or contact us for a directory or the names of network providers by calling 1-888/238-6240.

Out-of-network benefits apply when you use a non-network provider.

How we pay providers

We reimburse you or your provider for your covered services, usually based on a percentage of our Plan allowance. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

Network Providers

We negotiate rates with doctors, dentists and other health care providers to help save you money. We refer to these providers as “Network providers." These negotiated rates are our Plan allowance for network providers. We calculate a member’s coinsurance using these negotiated rates. The member is not responsible for amounts billed by network providers that are greater than our Plan allowance.

Non-Network Providers

Because they do not participate in our networks, non-network providers are paid by Aetna based on an out-of-network Plan allowance. Members are responsible for their coinsurance portion of our Plan allowance, as well as any expenses over that limit that the non-network provider may have billed. See the Plan allowance definition in Section 10 for more details on how we pay out-of-network claims.

Your rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM’s FEHB website (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Aetna has been in existence since 1850
- Aetna is a for-profit organization

If you want more information about us, call 1-888/238-6240 or write to Aetna at P.O. Box 550, Blue Bell, PA 19422-0550. You may also visit our website at www.aetnafeds.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Medical Necessity

"Medical necessity" means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- In accordance with generally accepted standards of medical practice; and,
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease; and,
- Not primarily for the convenience of you, or for the physician or other health care provider; and,
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

For these purposes, "generally accepted standards of medical practice," means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Only medical directors make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters for such decisions delineate any unmet criteria, standards and guidelines, and inform the provider and member of the appeal process.

All benefits will be covered in accordance with the guidelines determined by Aetna.

Ongoing Reviews

We conduct ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this Plan. If we determine that the recommended services and supplies are not covered benefits, you will be notified. If you wish to appeal such determination, you may then contact us to seek a review of the determination.

Authorization

Certain services and supplies under this Plan may require authorization by us to determine if they are covered benefits under this Plan. See section 3, "You need prior plan approval for certain services."

Patient Management

We have developed a patient management program to assist in determining what health care services are covered and payable under the health plan and the extent of such coverage and payment. The program assists members in receiving appropriate health care and maximizing coverage for those health care services.

Where such use is appropriate, our utilization review/patient management staff uses nationally recognized guidelines and resources, such as Milliman Care Guidelines® and InterQual® ISD criteria, to guide the precertification, concurrent review and retrospective review processes. To the extent certain utilization review/patient management functions are delegated to integrated delivery systems, independent practice associations or other provider groups ("Delegates"), such Delegates utilize criteria that they deem appropriate.

- **Precertification** Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or you. It also allows Aetna to coordinate your transition from the inpatient setting to the next level of care (discharge planning), or to register you for specialized programs like disease management, case management, or our prenatal program. In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments.

	Certain health care services, such as hospitalization or outpatient surgery, require precertification with Aetna to ensure coverage for those services. When you are to obtain services requiring precertification through a participating provider, this provider should precertify those services prior to treatment. **Note**: Since this Plan pays out-of-network benefits and you may self-refer for covered services, it is your responsibility to contact Aetna to precertify those services which require precertification. You must obtain precertification for certain types of care rendered by non- network providers to avoid a reduction in benefits paid for that care.
• **Concurrent Review**	The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
• **Discharge Planning**	Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/ benefits to be utilized by you upon discharge from an inpatient stay.
• **Retrospective Record Review**	The purpose of retrospective record review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of health care services. Our effort to manage the services provided to you includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Member Services

Representatives from Member Services are trained to answer your questions and to assist you in using the Aetna plan properly and efficiently. After you receive your ID card, you can call the Member Services toll-free number on the card when you need to:

- Ask questions about benefits and coverage.
- Notify us of changes in your name, address or telephone number.
- Obtain information about how to file a grievance or an appeal.

Privacy Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify you.

When necessary or appropriate for your care or treatment, the operation of our health plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claims payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health claims analysis and reporting; health services research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health plans. To the extent permitted by law, we use and disclose personal information as provided above without your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To obtain a hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to Aetna's Legal Support Services Department at 151 Farmington Avenue, W121, Hartford, CT 06156. You can also visit our Internet site at www.aetnafeds.com. You can link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link at the bottom of the page.

Protecting the privacy of member health information is a top priority at Aetna. When contacting us about this FEHB Program brochure or for help with other questions, please be prepared to provide you or your family member's name, member ID (or Social Security Number), and date of birth.

If you want more information about us, call 1-888-238-6240, or write to Aetna, Federal Plans, PO Box 550, Blue Bell, PA 19422-0550. You may also contact us by fax at 215-775-5246 or visit our website at www.aetnafeds.com.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our network providers practice. Our service areas are:

Alabama, Most of Alabama, Enrollment Code F5 – Autauga, Baldwin, Bibb, Blount, Bullock, Calhoun, Chambers, Cherokee, Chilton, Choctaw, Clarke, Clay, Cleburne, Coffee, Colbert, Coosa, Covington, Crenshaw, Cullman, Dale, Dallas, De Kalb, Elmore, Escambia, Etowah, Fayette, Franklin, Geneva, Greene, Hale, Henry, Houston, Jackson, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Limestone, Lowndes, Macon, Madison, Marengo, Marion, Marshall, Mobile, Monroe, Montgomery, Morgan, Perry, Pickens, Pike, Randolph, Russell, St. Clair, Shelby, Sumter, Talladega, Tallapoosa, Tuscaloosa, Walker, Washington, Wilcox and Winston counties.

Alaska, Most of Alaska, enrollment code JS - Aleutians East, Aleutians West, Anchorage, Bethel, Bristol Bay, Denali, Dillingham, Fairbanks North Star, Haines, Juneau, Kenai Peninsula, Ketchikan Gateway, Kodiak Island, Lake and Peninsula, Matanuska Susitna, Nome, North Slope, Prince of Wales outer Ketchikan, Sitka, Skagway Hoonah Angoon, Southeast Fairbanks, Valdez Cordova, Wade Hampton, Yakutat and Yukon Koyukuk boroughs.

Arizona, Enrollment Code G5 - All of Arizona.

Arkansas, Most of Arkansas, Enrollment Code F5 - Arkansas, Baxter, Benton, Boone, Bradley, Carroll, Clark, Clay, Cleburne, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Dallas, Drew, Faulkner, Franklin, Fulton, Garland, Grant, Greene, Hot Spring, Independence, Jackson, Jefferson, Johnson, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Miller, Mississippi, Monroe, Montgomery, Newton, Ouachita, Perry, Phillips, Poinsett, Polk, Pope, Prairie, Pulaski, Randolph, Saline, Scott, Sebastian, Sharp, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff and Yell counties.

California, Most of California, enrollment code JS - Alameda, Amador, Butte, Calaveras, Colusa, Contra Costa, El Dorado, Fresno, Humboldt, Imperial, Kern, Kings, Lake, Los Angeles, Madera, Marin, Merced, Monterey, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Solano, Sonoma, Stanislaus, Sutter, Tehama, Tulare, Tuolumne, Ventura, Yolo and Yuba counties.

Colorado, Enrollment Code G5 – All of Colorado.

Connecticut, Enrollment Code EP – All of Connecticut.

Delaware, Enrollment Code EP – All of Delaware.

District of Columbia, Enrollment Code F5 – All of Washington, DC.

Florida, Most of Florida, Enrollment Code F5 - Alachua, Baker, Bay, Bradford, Brevard, Broward, Calhoun, Charlotte, Citrus, Clay, Collier, Columbia, DeSoto, Dixie, Duval, Escambia, Flagler, Franklin, Gadsden, Gilchrist, Glades, Gulf, Hamilton, Hardee, Hendry, Hernando, Highlands, Hillsborough, Holmes, Indian River, Jackson, Jefferson, Lake, Lee, Leon, Levy, Liberty, Madison, Manatee, Marion, Martin, Miami-Dade, Monroe, Nassau, Okaloosa, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, St. Lucie, Santa Rosa, Sarasota, Seminole, St. Johns, Sumter, Suwannee, Taylor, Union, Volusia, Wakulla, Walton and Washington counties.

Georgia, Enrollment Code F5 - All of Georgia

Hawaii, enrollment code JS - All of Hawaii.

Idaho, Most of Idaho, Enrollment Code H4 - Ada, Adams, Bannock, Bear Lake, Benewah, Bingham, Blaine, Boise, Bonner, Bonneville, Boundary, Butte, Canyon, Caribou, Cassia, Custer, Elmore, Franklin, Fremont, Gem, Gooding, Jefferson, Jerome, Kootenai, Latah, Lincoln, Madison, Minidoka, Nez Perce, Oneida, Owyhee, Payette, Shoshone, Teton, Twin Falls, Valley, and Washington counties.

Illinois, Most of Illinois, Enrollment Code H4 - Alexander, Bond, Boone, Brown, Bureau, Calhoun, Cass, Champaign, Christian, Clark, Clay, Clinton, Coles, Cook, Crawford, Cumberland, De Kalb, Douglas, DuPage, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Jo Daviess, Johnson, Kane, Kankakee, Kendall, Knox, La Salle, Lake, Lawrence, Lee, Livingston, Logan, Macon, Macoupin, Madison, Marion, Marshall, Mason, Massac, McDonough, McLean, McHenry, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Ogle, Peoria, Perry, Piatt, Pope, Pulaski, Putnam, Randolph, Richland, Rock Island, St. Clair, Saline, Sangamon, Schuyler, Scott, Stark, Stephenson, Tazewell, Union, Vermilion, Wabash, Warren, Washington, Wayne, White, Whiteside, Will, Williamson, Winnebago and Woodford counties.

Indiana, enrollment code JS - All of Indiana.

Iowa, Enrollment Code H4 - All of Iowa.

Kansas, Most of Kansas, Enrollment Code G5 - Allen, Anderson, Atchison, Barber, Barton, Bourbon, Brown, Butler, Chase, Chautauqua, Cherokee, Cheyenne, Clark, Clay, Cloud, Coffey, Comanche, Cowley, Crawford, Decatur, Dickinson, Doniphan, Douglas, Edwards, Elk, Ellis, Ellsworth, Finney, Ford, Franklin, Geary, Gove, Graham, Grant, Gray, Greeley, Greenwood, Hamilton, Harper, Harvey, Haskell, Hodgeman, Jackson, Jefferson, Jewell, Johnson, Kearny, Kiowa, Kingman, Labette, Lane, Leavenworth, Lincoln, Linn, Logan, Lyon, Marion, Marshall, McPherson, Meade, Miami, Mitchell, Montgomery, Morris, Morton, Nemaha, Neosho, Ness, Norton, Osage, Osborne, Ottawa, Pawnee, Phillips, Pottawatomie, Pratt, Rawlins, Reno, Republic, Rice, Riley, Rooks, Rush, Russell, Saline, Scott, Sedgwick, Seward, Shawnee, Sheridan, Sherman, Smith, Stafford, Stanton, Stevens, Sumner, Thomas, Trego, Wallace, Wabaunsee, Washington, Wichita, Wilson, Woodson, and Wyandotte counties.

Kentucky, Most of Kentucky, Enrollment Code H4 - Adair, Allen, Anderson, Ballard, Barren, Bell, Boone, Bourbon, Boyd, Boyle, Bracken, Breathitt, Breckinridge, Bullitt, Butler, Caldwell, Calloway, Campbell, Carlisle, Carroll, Carter, Casey, Christian, Clark, Clinton, Crittenden, Cumberland, Daviess, Edmonson, Elliott, Estill, Fayette, Floyd, Franklin, Fulton, Gallatin, Garrard, Grant, Graves, Grayson, Green, Greenup, Hancock, Hardin, Harlan, Harrison, Hart, Henderson, Henry, Hopkins, Jefferson, Jessamine, Johnson, Kenton, Knott, Larue, Lawrence, Letcher, Lewis, Lincoln, Livingston, Logan, Lyon, Madison, Magoffin, Marion, Marshall, Martin, Mason, McCracken, McCreary, McLean, Meade, Mercer, Metcalfe, Monroe, Montgomery, Morgan, Muhlenberg, Nelson, Ohio, Oldham, Owen, Pendleton, Perry, Pike, Pulaski, Robertson, Russell, Scott, Shelby, Simpson, Spencer, Taylor, Todd, Trigg, Trimble, Union, Warren, Washington, Wayne, Webster, Whitley, and Woodford counties.

Louisiana, Most of Louisiana, Enrollment Code F5 - Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, De Soto, East Baton Rouge, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson, Jefferson Davis, La Salle, Lafayette, Lafourche, Lincoln, Livingston, Madison, Morehouse, Natchitoches, Orleans, Ouachita, Plaquemines, Pointe Coupee, Rapides, Red River, Richland, Sabine, Saint Bernard, Saint Charles, Saint Helena, Saint James, Saint Landry, Saint Martin, Saint Mary, Saint Tammany, St John The Baptist, Tangipahoa, Tensas, Terrebonne, Union, Vermilion, Washington, Webster, West Baton Rouge, West Carroll, West Feliciana and Winn parishes and portions of the following counties as defined by the zip codes below:

Concordia - 71326, 71334, 71377

Maine, Enrollment Code EP – All of Maine.

Maryland, Enrollment Code F5 – All of Maryland.

Massachusetts , Most of Massachusetts, Enrollment Code EP – Barnstable, Berkshire, Bristol, Dukes, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk and Worcester counties.

Michigan, Enrollment Code G5 - All of Michigan.

Minnesota, Most of Minnesota, Enrollment Code H4 - Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cottonwood, Crow Wing, Dakota, Dodge, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac Qui Parle, Lake, Lake Of The Woods, LeSueur, Lincoln, Lyon, Mahnomen, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Ramsey, Redwood, Renville, Rice, Rock, Roseau, St. Louis, Scott, Sherburne, Sibley, Stearns, Steele, Stevens, Swift, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright, and Yellow Medicine counties.

Mississippi, Most of Mississippi, Enrollment Code H4 - Adams, Alcorn, Amite, Attala, Benton, Bolivar, Calhoun, Carroll, Chickasaw, Claiborne, Clarke, Clay, Coahoma, Copiah, Covington, De Soto, Forrest, Franklin, George, Grenada, Hancock, Harrison, Hinds, Holmes, Issaquena, Itawamba, Jackson, Jefferson Davis, Jones, Lafayette, Lamar, Lauderdale, Lawrence, Leake, Lee, Leflore, Lincoln, Lowndes, Madison, Marion, Marshall, Monroe, Neshoba, Newton, Noxubee, Oktibbeha, Panola, Pearl River, Perry, Pike, Pontotoc, Prentiss, Quitman, Rankin, Scott, Simpson, Smith, Stone, Sunflower, Tallahatchie, Tate, Tippah, Tishomingo, Tunica, Union, Walthall, Warren ,Washington, Wayne, Webster, Yalobusha and Yazoo counties.

Missouri, Most of Missouri, Enrollment Code G5 - Adair, Andrew, Atchison, Audrain, Barry, Barton, Bates, Benton, Boone, Buchanan, Caldwell, Callaway, Camden, Cape Girardeau, Carroll, Cass, Cedar, Chariton, Christian, Clark, Clay, Clinton, Cole, Cooper, Crawford, Dade, Dallas, Daviess, De Kalb, Dent, Douglas, Franklin, Gasconade, Gentry, Greene, Grundy, Harrison, Hickory, Henry, Holt, Howard, Howell, Jackson, Jasper, Jefferson, Johnson, Knox, Laclede, Lafayette, Lawrence, Lewis, Lincoln, Linn, Livingston, Macon, Madison, Maries, McDonald, Mercer, Miller, Moniteau, Monroe, Montgomery, Morgan, Newton, Nodaway, Osage, Ozark, Pettis, Phelps, Platte, Polk, Pulaski, Putnam, Ralls, Randolph, Ray, Saint Clair, Saline, Schuyler, Scotland, Shannon, St. Charles, St. Francois, St. Louis, St. Louis City, Ste. Genevieve, Stone, Sullivan, Taney, Texas, Vernon, Warren, Washington, Webster, Worth and Wright counties.

Montana, South, Southeast and Western MT, Enrollment Code H4 -Beaverhead, Big Horn, Blaine, Broadwater, Carbon, Cascade, Chouteau, Custer, Daniels, Dawson, Deer Lodge, Fallon, Fergus, Flathead, Gallatin, Glacier, Golden Valley, Granite, Hill, Jefferson, Judith Basin, Lake, Lewis And Clark, Liberty, Lincoln, Meagher, Mineral, Missoula, Musselshell, Park, Petroleum, Phillips, Pondera, Powder River, Powell, Prairie, Ravalli, Richland, Rosebud, Sanders, Sheridan, Silver Bow, Stillwater, Sweet Grass, Teton, Toole, Treasure, Valley, Wheatland and Yellowstone counties.

Nebraska, Enrollment Code H4 - All of Nebraska

Nevada , Las Vegas, Enrollment Code G5 – Carson City, Churchill, Clark, Douglas, Elko, Humboldt, Lander, Lyon, Mineral, Nye, Pershing, Storey, Washoe and White Pine counties.

New Hampshire, Enrollment Code EP – All of New Hampshire.

New Jersey, Enrollment Code EP – All of New Jersey.

New Mexico, Albuquerque, Dona Ana and Hobbs areas, Enrollment Code G5 - Bernalillo, Chaves, Cibola, Dona Ana, Lea, Los Alamos, Luna, Otero, San Juan, Sandoval, Santa Fe, Torrance, and Valencia counties.

New York, Most of New York, Enrollment Code EP - Albany, Allegany, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming, and Yates counties and portions of the following counties as defined by the zip codes below:

Saint Lawrence - 12922, 12927, 12965, 12967, 13613, 13614, 13617, 13621, 13623, 13625, 13630, 13633, 13635, 13639, 13642, 13643, 13646, 13647, 13649, 13652, 13654, 13658, 13660, 13662, 13664, 13666, 13667, 13668, 13669, 13670, 13672, 13676, 13677, 13678, 13680, 13681, 13683, 13684, 13687, 13690, 13694, 13695, 13696, 13697, 13699

North Carolina, Enrollment Code F5 - All of North Carolina.

North Dakota, Most of North Dakota, Enrollment Code H4 - Barnes, Benson, Billings, Bottineau, Burleigh, Cass, Cavalier, Dickey, Eddy, Emmons, Foster, Grand Forks, Griggs, Kidder, Lamoure, Logan, McHenry, McIntosh, McLean, Mercer, Morton, Nelson, Oliver, Pembina, Pierce, Ramsey, Ransom, Richland, Rolette, Sargent, Sheridan, Sioux, Slope, Stark, Steele, Stutsman, Towner, Traill, Walsh, Ward and Wells counties.

Ohio, enrollment code JS - All of Ohio.

Oklahoma, enrollment code JS - All of Oklahoma.

Oregon, Most of Oregon, Enrollment Code H4 - Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Gilliam, Harney, Hood River, Jackson, Jefferson, Josephine, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Tillamook, Umatilla, Union, Wasco, Washington and Yamhill counties.

Pennsylvania, Enrollment Code H4 - All of Pennsylvania.

Rhode Island, Enrollment Code EP - All of Rhode Island.

South Carolina, enrollment code JS - All of South Carolina.

South Dakota, Rapid City and Sioux Falls, Enrollment Code G5 - Bonne Homme, Butte, Clay, Custer, Fall River, Lawrence, Lincoln, Meade, Minnehaha, Pennington, Turner, Union, and Yankton counties.

Tennessee, Most of Tennessee, Enrollment Code F5 - City of Jackson and Anderson, Bedford, Benton, Bledsoe, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Clay, Cocke, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hardin, Hawkins, Haywood, Henderson, Henry, Hickman, Houston, Humphreys, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, McNairy, Meigs, Monroe, Montgomery, Moore, Morgan, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott , Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Wayne, Weakley, White, Williamson and Wilson counties.

Texas, enrollment code JS - All of Texas.

Utah - Most of Utah, Enrollment Code G5 - Beaver, Box Elder, Cache, Carbon, Davis, Duchesne, Emery, Garfield, Iron, Juab, Kane, Millard, Morgan, Piute, Rich, Salt Lake, San Juan, Sanpete, Sevier, Summit, Tooele, Uintah, Utah, Wasatch, Washington, Wayne and Weber counties.

Vermont, Enrollment Code EP - All of Vermont.

Virginia, Most of Virginia, Enrollment Code F5 – Albemarle, Alleghany, Amelia, Amherst, Appomattox, Arlington, Bedford, Bland, Botetourt, Bristol, Buchanan, Buckingham, Campbell, Caroline, Carroll, Charles City, Charlotte, Chesterfield, Clarke, Covington City, Craig, Culpeper, Cumberland, Dickenson, Dinwiddie, Essex, Fairfax, Fauquier, Floyd, Fluvanna, Franklin, Frederick, Galax City, Giles, Gloucester, Goochland, Grayson, Halifax, Hanover, Henrico, Henry, Isle Of Wight, James City, King And Queen, King George, King William, Lancaster, Lee, Loudon, Louisa, Lunenburg, Martinsville City, Mathews, Middlesex, Montgomery, Nelson, New Kent, Northumberland, Norton City, Nottoway, Orange, Patrick, Pittsylvania, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Radford, Roanoke, Roanoke City, Russell, Salem, Scott, Shenandoah, Smyth, Southampton, Spotsylvania, Stafford, Surry, Sussex, Tazewell, Warren, Washington, Westmoreland, Wise, Wythe and York counties and;

The cities of Alexandria, Charlottesville, Chesapeake, Colonial Heights, Covington, Danville, Fairfax, Falls Church, Franklin, Fredericksburg, Galax, Hampton, Harrisonburg, Hopewell, Lexington, Lynchburg, Manassas, Manassas Park, Martinsville, Newport News, Norfolk, Norton, Petersburg, Poquoson, Portsmouth, Richmond, Roanoke, Suffolk, Virginia Beach, Williamsburg and Winchester.

Washington, Most of Washington, Enrollment Code G5 – Adams, Asotin, Benton, Chelan, Clallam, Clark, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Skamania, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman and Yakima counties.

West Virginia, Most of West Virginia, Enrollment Code F5 – Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Greenbrier, Hampshire, Hancock, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pleasants, Preston, Putnam, Raleigh, Ritchie, Roane, Summers, Taylor, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood and Wyoming counties.

Wisconsin, enrollment code JS - All of Wisconsin.

Wyoming, Enrollment Code H4 - All of Wyoming.

If you or a covered family member move or live outside of our service areas, you can continue to access out-of-network care or you can enroll in another plan. If you or a covered family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2016

- Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.
- **Program-wide changes**
  - Self Plus One enrollment type has been added effective January 1, 2016

Changes to our Consumer Driven Health Plan (CDHP)

- **Specialty prescription drugs –** The Plan will add a 5th Tier for non-preferred specialty drugs. Members will pay 50% up to a maximum of $500 per drug for a 30-day supply. (See page 80)
- **Prescription drugs** - The Plan will increase the non-formulary (Tier 3) copayment from $60 to $75 for a 30-day supply and $120 to $150 for up to a 90-day supply through mail order. (See page 79)
- **Catastrophic protection out-of-pocket maximum** - The Plan will decrease the in-network out-of-pocket maximum from $8,000 to $6,850 for Self Plus One and Self and Family enrollments. (See page 31)

Changes to our Value Plan

- **Alternative medicine treatments -** The Plan will add coverage for chiropractic services and increase coverage for acupuncture services limited to a combined 20 total visits. (See page 99)
- **Specialty prescription drugs –** The Plan will add a 5th Tier for non-preferred specialty drugs. Members will pay 50% up to a maximum of $1,200 per drug for a 30-day supply. (See page 123)
- **Member cost sharing -** The Plan will no longer require members to satisfy the in-network deductible prior to paying applicable cost sharing for prescription drugs. (See page 119)
- **Catastrophic protection out-of-pocket maximum** - The Plan will decrease the in-network out-of-pocket maximum from $10,000 to $6,850 for Self Plus One and Self and Family enrollments. (See page 32)

Changes to our Consumer Driven Health Plan (CDHP) and Value Plan

- **Enrollment code EP**. Your share of the non-Postal premium under the Consumer Driven Health Plan (CDHP) and Value Plan options will increase for Self Only and increase for Self and Family. (See page 156)
- **Enrollment code F5**. Your share of the non-Postal premium under the Consumer Driven Health Plan (CDHP) and Value Plan options will increase for Self Only and increase for Self and Family. (See page 157)
- **Enrollment code G5**. Your share of the non-Postal premium under the Consumer Driven Health Plan (CDHP) and Value Plan options will increase for Self Only and increase for Self and Family. (See page 157)
- **Enrollment code H4**. Your share of the non-Postal premium under the Consumer Driven Health Plan (CDHP) and Value Plan options will increase for Self Only and increase for Self and Family. (See page 157)
- **Enrollment code JS.** Your share of the non-Postal premium under the Consumer Driven Health Plan (CDHP) and Value Plan options will increase for Self Only and increase for Self and Family. (See page 158)
- **Teladoc** - The Plan will now offer telehealth consultation services. Specialist cost sharing applies. Teladoc is not available for service in Missouri, Idaho and Arkansas. (See pages 49 and 91)
- **Services that require plan approval (other services)** - The Plan updated its list of services that require plan approval which now includes: dental implants, transportation by plane, diagnostic studies such as sleep studies, dialysis and private duty nursing, breast cancer genetic testing, ventricular assist devices and outpatient surgery at non-participating ambulatory surgery center when referred by a participating provider. (See page 24)
- **Maternity care –** The Plan now allows a total of three (3) days or less for vaginal delivery or a total of five (5) days or less for cesarean delivery. (See page 27)

- **Emergency inpatient admission –** The Plan now requires the member, member's representative, physician or hospital to inform the Plan within one (1) business day following the emergency admission of the member. (See page 27)
- **Infertility** - The Plan will no longer cover artificial insemination. (See pages 51 and 93)
- **Physical and occupational therapy –** The Plan will change coverage to now provide 60 total visits per person per calendar year for physical or occupational therapy or combination of both. (See pages 53 and 95)
- **Speech therapy –** The Plan will change coverage to now provide 60 total visits per person per calendar year for speech therapy. (See pages 54 and 96)
- **Prescription drugs –** The Plan will now require members to utilize at least 80% of a prescribed medication before it can be refilled. (See pages 78 and 121)
- **Limited quantity prescription drugs –** The Plan will change the cost sharing for Imitrex and Erectile Dysfunction drugs from 50% of the Plan's allowance to the Plan's applicable Formulary copayments. (See pages 80 and 123)
- **Surgical treatment of morbid obesity (Bariatric Surgery) –** The Plan no longer requires the condition to persist for at least two (2) years. (See pages 59 and 101)
- **Service area expansions** - The Plan expanded its service area in the enrollment codes and states below:
  - Florida (code F5) – DeSoto and Madison counties
  - Kansas (code G5) – Barber, Decatur, Edwards, Gove, Jackson, Kiowa, Lane, Mitchell, Nemaha, Norton, Rawlins, Rush, Sheridan, Sherman, Wallace and Wabaunsee counties
  - Kentucky (code H4) – Montgomery County
  - Missouri (code G5) – Johnson County
  - South Dakota (code G5) – Butte County
  - Tennessee (code F5) – Monroe, Polk and Rhea counties

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. If you enroll as Self Plus One or Self and Family, you will receive two Family ID cards. You should carry your ID card with you at all times. You must show it whenever you receive services from a Network provider or fill a prescription at a Network pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-888-238-6240 or write to us at Aetna, P.O. Box 14079, Lexington, KY 40512-4079. You may also request replacement cards through our Navigator website at www.aetnafeds.com.

Where you get covered care

You can get care from any licensed provider or licensed facility. How much we pay – and you pay – depends on whether you use a network or non-network provider or facility. If you use a non-network provider, you will pay more.

- **Network providers**

Network providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Network providers according to national standards.

We list Network providers in the provider directory, which we update periodically. The most current information on our Network providers is also on our website at www.aetnafeds.com under DocFind.

- **Network facilities**

Network facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these facilities in the provider directory, which we update periodically. The most current information on our Network facilities is also on our website at www.aetnafeds.com under DocFind.

- **Non-network providers and facilities**

You can access care from any licensed provider or facility. Providers and facilities not in Aetna's networks are considered non-network providers and facilities.

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance.

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and lose access to your network specialist because we:

- Terminate our contract with your specialist for other than cause; or
- Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Program plan; or
- Reduce our service area and you enroll in another FEHB plan,

you may be able to continue seeing your specialist and receive any in-network benefits for up to 90 days after you receive notice of the change. Contact us, or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and any in-network benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Network primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

Note: Non-network physicians generally will make these arrangements too, but you are responsible for any precertification requirements.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 1-888-238-6240. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your plan physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services*.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

In most cases, your Network physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted us.

Some services require prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. We call this review and approval process precertification.

When you see a Plan physician, that physician must obtain approval for certain services such as inpatient hospitalization and the following services. If you see a non-participating physician you must obtain approval.

- Certain non-emergent surgery, including but not limited to obesity surgery, lumbar disc and spinal fusion surgery, reconstructive procedures and correction of congenital defects, sleep apnea surgery, TMJ surgery and dental implants, and joint grafting procedures;
- Covered transplant surgery;
- Transportation by fixed-wing aircraft (plane);
- Skilled nursing facilities, rehabilitation facilities, and inpatient hospice; and skilled nursing under Home Health Care;
- Certain mental health services, including residential treatment centers, partial hospitalization programs, intensive outpatient treatment programs including detoxification and electroconvulsive therapy, psychological and neuropsychological testing, biofeedback and amytal interview;
- Certain oral and injectable drugs before they can be prescribed including but not limited to botulinum toxin, alpha-1-proteinase inhibitor, palivizumab(Synagis), erythropoietin therapy, intravenous immunoglobulin, growth hormone, blood clotting factors and interferons when used for hepatitis C;

- Certain outpatient imaging and diagnostic studies such as sleep studies, CT scans, MRIs, MRAs, nuclear stress tests, and GI tract imaging through capsule endoscopy;
- Proton beam radiotherapy;
- Cognitive skills development;
- Dialysis and private duty nursing;
- Certain wound care such as hyperbaric oxygen therapy;
- Certain limb prosthetics;
- Cochlear device and/or implantation;
- Percutaneous implant of nerve stimulator;
- BRCA and breast cancer genetic testing;
- In-network infertility services;
- Gender reassignment surgery;
- Ventricular assist devices;
- Outpatient surgery at a non-participating ambulatory surgery center when referred by a participating provider.

You or your physician must obtain an approval for certain durable medical equipment (DME) including but not limited to electric or motorized wheelchairs, electric scooters, electric beds, and customized braces.

Members must call Member Services at 1-888/238-6240 for authorization.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 1-888/238-6240 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

If the admission is a non-urgent admission or if you are being admitted to a Non-network hospital, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an emergency or an urgent admission, you, the person's physician, or the hospital must get the days certified by calling the number shown on your ID card. This must be done:

- Before the start of a confinement as a full-time inpatient which requires an urgent admission; or
- Not later than one (1) business day following the start of a confinement as a full-time inpatient which requires an emergency admission; unless it is not possible for the physician to request certification within that time. In that case, it must be done as soon as reasonably possible. In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.

If, in the opinion of the person's physician, it is necessary for the person to be confined for a longer time than already certified, you, the physician, or the hospital may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the hospital. A copy will be sent to you and to the physician.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 45 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you verbally within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours from the receipt of this notice to provide the required information. We will make our decision on the claim within 48 hours (1) of the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-888/238-6240. You may also call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-888/238-6240. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within one (1) business day following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than a total of three (3) days or less for a vaginal delivery or a total of five (5) days or less for a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **What happens when you do not follow the precertification rules when using non-network facilities**

- If no one contacts us, we will decide whether the hospital stay was medically necessary.
  - If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.
  - If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.
- If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.
- When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:
  - for the part of the admission that was medically necessary, we will pay inpatient benefits, but
  - for the part of the admission that was not precertified or not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your cost for covered services

This is what you will pay out-of-pocket for covered care:

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copay is the fixed amount of money you pay when you receive certain services. Example: You pay a copayment of $10 to the pharmacy when you receive generic drugs on our formulary list.

Example: When you see your primary care physician, you pay a copayment of $10 per office visit, and when you go in the hospital, you pay $100 per admission.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them.

Consumer Driven Health Plan (CDHP)

After you have used up your Medical Fund, you must satisfy your deductible. Your deductible is $1,000 for Self Only, $2,000 for Self Plus One or $2,000 for Self and Family enrollment. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $1,000. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment plan reach $2,000. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reaches $2,000. There is no individual limit within the Self Plus One or Self and Family deductible.

Note: If you change plans (*except if you change Aetna CDHP options) during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

*Note: If you change from one Aetna CDHP option to another Aetna CDHP option during Open Season then you will receive your annual Medical Fund and your annual deductible will begin on January 1, regardless of your open season effective date.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Value Plan

You must satisfy your deductible before your Traditional medical coverage begins. Note: Preventive services, PCP office visits and Specialist office visits are not subject to the annual deductible. Your annual deductible is $600 for a Self Only enrollment, $1,200 for a Self Plus One enrollment and $1,200 for Self and Family enrollment in-network and $1,250 for a Self Only enrollment, $2,500 for a Self Plus One, and $2,500 for a Self and Family enrollment out-of-network. The Self Plus One and Self and Family deductible can be satisfied by one or more members. There is no individual limit within the Self Plus One or Self and Family deductible.

Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 15% of our Plan allowance for in-network durable medical equipment under CDHP and 20% of our Plan allowance under the Value Plan.

Differences between our Plan allowance and the bill

Network Providers agree to accept our Plan allowance so if you use a network provider, you never have to worry about paying the difference between our Plan allowance and the billed amount for covered services.

Non-Network Providers: If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount.

By using health care providers in Aetna's network, you can take advantage of the significant discounts we have negotiated to help lower your out-of-pocket costs for medically necessary care. This can help you get the care you need at a lower price.

The example below is based on the following Aetna health benefits and insurance plan features and assumes you've already met your deductible:

What your plan pays (plan coinsurance): 85% in-network/60% out-of-network

What you pay (coinsurance): 15% in-network/40% out-of-network

Your out-of-pocket maximum: $4,000/$6,850 in-network; $5,000/$10,000 out-of-network***

Example: A five-day hospital stay- comparison of member costs in network versus out-of-network (see additional examples on our website: www.aetnafeds.com)

		In-network	Out-of-network
Hospital bill	Amount billed	$25,000	$25,000
Amount Aetna uses to calculate payment	in-network rate*	$8,750	
Amount Aetna uses to calculate payment	Recognized amount** out-of-network		$8,750
What your Aetna plan will pay	Negotiated / recognized amount	$8,750	$8,750
What your Aetna plan will pay	Percent your plan pays	85%	60%
What your Aetna plan will pay	Aetna's negotiated rate/recognized amount covered under plan	$7,437.50	$5,250
What you owe	Your coinsurance responsibility (In-network 15%, Out-of-network 40%)	$1,312.50	$3,500
What you owe	Amount that can be balance billed to you	$0	$16,250
What you owe	Your total responsibility	$1,312.50	$19,750

*Doctors, hospitals and other health care providers in Aetna's network accept Aetna's payment rate and agree that you owe only your deductible and coinsurance.

**When you go out of network, Aetna determines a recognized amount. You may be responsible for the difference between the billed amount and the recognized amount. In these examples, we have assumed that the recognized amount and the negotiated rate are the same amount. Actual amounts will vary.

***Your plan caps out-of-pocket costs for covered services. The deductible and coinsurance you owe count toward that cap. But when you go out of network, the difference between the health care provider's bill and the recognized amount does not count toward that cap.

Your catastrophic protection out-of-pocket maximum

Out-of-pocket maximums are the amount of out-of-pocket expenses that a Self Only, Self Plus One or a Self and Family will have to pay in a plan year. Out-of-pocket maximums apply on a calendar year basis only. The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%. Be sure to keep accurate records and receipts of your copayments, applicable deductible and coinsurance to ensure the Plan's calculation of your out-of-pocket maximum is reflected accurately.

CDHP

Only your deductible and those out-of-pocket expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the out-of-pocket maximums. This includes dollars you have paid toward your deductible and coinsurance.

Note: For the CDHP, once you have met your deductible, and satisfied your out-of-pocket maximums, eligible medical expenses will be covered at 100%.

If you have met your deductible the following would apply:

Self Only:

In-network: Your annual out-of-pocket maximum is $4,000.

Out-of-network: Your annual out-of-pocket maximum is $5,000.

Self Plus One:

In-network: Your annual out-of-pocket maximum is $6,850.

Out-of-network: Your annual out-of-pocket maximum is $10,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is $6,850.

Out-of-network: Your annual out-of-pocket maximum is $10,000.

The following cannot be included in the accumulation of out-of-pocket expenses:

- Any expenses paid by the Plan under your In-network Preventive Care benefit
- Expenses in excess of our Plan allowance or maximum benefit limitations or expenses not covered under the Traditional medical coverage
- Any coinsurance expenses you have paid for infertility services
- Dental care expenses above the maximum limitations provided under your Dental Fund
- The $500 penalty for failure to obtain precertification when using a Non-network facility and any other amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements

Value Plan

Only the deductible and those out-of-pocket expenses resulting from the application of coinsurance percentage (except any penalty amounts) and copayments may be used to satisfy the out-of-pocket maximums.

Note: For the Value option, once you have met your deductible and satisfied your out-of-pocket maximums, eligible medical expenses will be covered at 100%.

If you have met your deductible, the following would apply:

Self Only:

In-network: Your annual out-of-pocket maximum is $5,000.

Out-of-network: Your annual out-of-pocket maximum is $5,000.

Self Plus One:

In-network: Your annual out-of-pocket maximum is $6,850.

Out-of-network: Your annual out-of-pocket maximum is $10,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is $6,850.

Out-of-network: Your annual out-of-pocket maximum is $10,000.

The following cannot be included in the accumulation of out-of-pocket expenses:

- Any expenses paid by the Plan under your In-network Preventive Care benefit
- Expenses in excess of our Plan allowance or maximum benefit limitations or expenses not covered under the Traditional medical coverage
- Any coinsurance expenses you have paid for infertility services
- The $500 penalty for failure to obtain precertification when using a Non-network facility and any other amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements

Carryover

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Consumer Driven Health Plan Benefits

See page 21 for how our benefits changed this year and pages 152-153 for a benefits summary.

Section 5. Consumer Driven Health Plan Benefits Overview

This Plan offers a Consumer Driven Health Plan (CDHP). The CDHP benefit package is described here in this Section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

CDHP Section 5, which describes the CDHP benefits, is divided into subsections. Please read *Important things you should keep in mind* at the beginning of each subsection. Also, read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about CDHP benefits, contact us at 1-888/238-6240 or on our website at www.aetnafeds.com.

The Aetna HealthFund Consumer Driven Health Plan (CDHP) focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. With this Plan, eligible in-network medical and dental preventive care is covered in full, and you can use the Medical Fund for any other covered care. If you use up your Medical Fund, the Traditional medical coverage begins after you satisfy your deductible. If you don't use up your Medical Fund for the year, you can roll it over to the next year, up to the maximum rollover amount ($5,000 Self Only enrollment/ $10,000 Self Plus One enrollment/ $10,000 Self and Family enrollment), as long as you continue to be enrolled in the Aetna HealthFund CDHP.

The Aetna HealthFund CDHP includes these five key components:

- **In-Network Medical and Dental Preventive Care**

  This component covers 100% for preventive care for adults and children if you use a network provider. The covered medical services include office visits/exams, immunizations and screenings, and the covered dental services include oral evaluations, cleanings, x-rays, fluoride applications, sealants, and space maintainers. These services are fully described in Section 5. The services are based on recommendations by the American Medical Association, the American Academy of Pediatrics, and the American Dental Association. You do not have to meet the deductible before using these services.

- **Aetna HealthFund (Medical and Dental Funds)**

  The Plan provides an annual Medical Fund for each enrollment. For 2016, the Plan provides $1,000 for a Self Only enrollment, $2,000 for a Self Plus One enrollment, or $2,000 for a Self and Family enrollment. The Medical Fund covers 100% of your eligible medical expenses. The Medical Fund is described in greater detail in Section 5.

  Health Incentive Credit: The Plan will provide a health incentive credit for an enrollee or spouse who completes the Plan's "Simple Steps To A Healthier Life® Health Assessment," an online wellness program, and a post program assessment. The post-program assessment becomes available to you 30 days after you complete the pre-program survey to enroll in the online wellness program. You have 30 days to complete the post-program assessment to earn your initial credit. The Plan will credit the Medical Fund $50 per enrollee and/or spouse up to an annual family limit of $100 upon completion of the health assessment, online wellness program, and post-program assessment.

  Biometric Screening with Incentive: (Available February 1st - December 31st) The Plan will provide biometric screenings for members (over 18 years of age) with no cost sharing. Screenings must include total cholesterol, HDL, calculated LDL, calculated cholesterol/HDL ratio, triglycerides and glucose, blood pressure and waist circumference. The Plan will credit the member's medical fund with an incentive of $50 per enrollee and/or spouse, up to an annual family limit of $100 for biometric screening. Members obtain the screening at a Quest Diagnostics Patient Service Center (PSC). If you are not located within 20 miles of a Quest Diagnostics PSC, you may send the appropriate form to your physician's office and request that your physician complete the form and fax or mail it back to Quest. Visit www.aetnafeds.com for information on setting up an appointment at a Quest PSC or to obtain the form if you are not located within 20 miles of a Quest PSC. The biometric screening incentive is separate from the health incentive the Plan currently offers for completion of specific wellness activities.

  The Plan also provides an annual Dental Fund for each enrollment. Each year, the Plan provides $300 for a Self Only enrollment, $600 for a Self Plus One enrollment or $600 for a Self and Family enrollment.

The Dental Fund covers 100% of your eligible dental expenses. The Dental Fund is described in greater detail in Section 5.

If you have an unused Medical or Dental Fund balance at the end of the calendar year, that balance will roll over so you can use it in the future, as long as you continue to participate in the Plan. If you terminate your participation in the Plan, your Medical and Dental Fund balances are lost.

The Medical Fund is not a cash account and has no cash value. It does not duplicate other coverage provided by this brochure. It will be terminated if you are no longer covered by this Plan. Only eligible expenses incurred while covered under the Plan will be eligible for reimbursement subject to timely filing requirements. Unused Medical Funds are forfeited if you are no longer covered under the Plan.

Note: In-Network Medical and Dental Preventive Care benefits paid under Section 5 do NOT count against your Medical or Dental Funds.

- **Traditional medical coverage subject to the deductible**

Under Traditional medical coverage, you must first use your annual Medical Fund and then satisfy your deductible of $1,000 for Self Only enrollment, $2,000 for Self Plus One enrollment or $2,000 for Self and Family enrollment. Once you have satisfied your deductible, the Plan generally pays 85% of the cost for in-network care and 60% for out-of-network care.

- **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual maximum for out-of-pocket expenses (deductible and coinsurance) for covered services is limited to $4,000 for Self Only, $6,850 for Self Plus One, or $6,850 for Self and Family enrollment. If you use non-network providers, your out-of-pocket maximum is $5,000 for Self Only, $10,000 for Self Plus One, or$10,000 for Self and Family enrollment. The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and CDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

Connect to www.aetnafeds.com for access to Aetna Navigator, a secure and personalized member site offering you a single source for health and benefits information. Use it to:

- Perform self-service functions, like checking your fund balance or the status of a claim.

Aetna Navigator gives you direct access to:

- Personal Health Record that provides you with online access to your personal health information including health care providers, drug prescriptions, medical tests, individual personalized messages, alerts, and a detailed health history that can be shared with your physicians.
- Cost of Care tools that compare in-network and out-of-network provider fees, the cost of brand-name drugs vs. their generic equivalents, and the costs for services such as routine physicals, emergency room visits, lab tests, X-rays, MRIs, etc.
- Member Payment Estimator that provides real-time, out-of-pocket estimates for medical expenses based on your Aetna health plan. You can compare the cost of doctors and facilities before you make an appointment, helping you budget for an manage health care expenses.
- A hospital comparison tool that allows you to see how hospitals in your area rank on measures important to your care.
- Our DocFind® online provider directory.

- Online customer service that allows you to request member ID cards, send secure messages to Member Services, and more.
- Healthwise® Knowledgebase where you get information on thousands of health-related topics to help you make better decisions about your health care and treatment options.

Section 5. Medical and Dental Preventive Care

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Preventive care is health care services designed for prevention and early detection of illness in average risk, people without symptoms, generally including routine physical examinations, tests and immunizations. We follow the U.S. Preventive Services Task Force recommendations for preventive care unless noted otherwise. For more information visit www.aetnafeds.com.
- The Plan pays 100% for the medical and dental preventive care services listed in this Section as long as you use a network provider.
- If you choose to access preventive care with an out-of-network provider, you will not qualify for 100% preventive care coverage. Please see Section 5 – Medical and Dental Funds, and Section 5 – Traditional medical coverage subject to the deductible.
- For preventive care not listed in this Section or preventive care from a non-network provider, please see Section 5 – Medical and Dental Funds.
- For all other covered expenses, please see Section 5 – Medical and Dental Funds and Section 5 – Traditional medical coverage subject to the deductible.
- Note that the in-network medical and dental preventive care paid under this Section does NOT count against or use up your Medical or Dental Funds.

Benefit Description	You pay
Medical Preventive Care, adult	
Routine screenings, such as: • Blood tests • Routine urine tests • Total Blood Cholesterol • Fasting lipid profile • Routine Prostate Specific Antigen (PSA) test — one annually for men age 40 and older • Colorectal Cancer Screening, including - Fecal occult blood test yearly starting at age 50 - Sigmoidoscopy screening — every five years starting at age 50 - Colonoscopy screening — every 10 years starting at age 50 • Lung Cancer Screening - 1 screening annually from age 55 and over Note: Physician consultation for colorectal screening visits prior to the procedure are not considered preventive. • Routine annual digital rectal exam (DRE) for men age 40 and older • Abdominal Aortic Aneurysm Screening – ultrasonography, one screening for men age 65 and older • Dietary and nutritional counseling for obesity - 26 visits annually	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (see Section 5).
Well woman care including, but not limited to: • Routine well woman exam (one visit per calendar year) • Routine Pap test	In-network: Nothing at a network provider.

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay
Medical Preventive Care, adult (cont.)	
• Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immune-deficiency virus. • Generic contraceptive methods and counseling. (See page 80) • Screening and counseling for interpersonal and domestic violence.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (see Section 5).
• Routine mammogram - covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40 to 64, one every calendar year - At age 65 and older, one every two consecutive calendar years • Routine Osteoporosis Screening - For women 65 and older - At age 60 for women at increased risk • Routine physicals: - One exam every 2 calendar years up to age 65 - One exam every calendar year age 65 and older • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) such as: - Tetanus, Diphtheria and Pertussis (Tdap) vaccine as a single dose for those 19 years of age and above - Tetanus-Diphtheria (Td) booster every 10 years - Influenza vaccine, annually - Varicella (chicken pox) vaccine for age 19 to 49 years without evidence of immunity to varicella - Pneumococcal vaccine, age 65 and over - Human papilloma virus (HPV) vaccine for age 18 through age 26 - Herpes Zoster (Shingles) vaccine for age 60 and older The following exams limited to: • 1 routine eye exam every 12 months • 1 routine hearing exam every 24 months Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 1-888/238-6240 for information on whether a specific test is considered routine.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (see Section 5).
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay
Medical Preventive Care, adult (cont.)	
Not covered: • *Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.*	*All charges*
Medical Preventive Care, children	
• We follow the American Academy of Pediatrics (AAP) recommendations for preventive care and immunizations. Go to www.aetnafeds.com for the list of preventive care and immunizations recommended by the American Academy of Pediatrics. • Well-child care charges for routine examinations, immunizations and care (up to age 22) - 7 routine exams from birth to age 12 months - 3 routine exams from age 12 months to 24 months - 3 routine exams from age 24 months to 36 months - 1 routine exam per year thereafter to age 22 • Screening examination of premature infants for Retinopathy of Prematurity-A retinal eye screening exam performed by an ophthalmologist for infants with low birth weight (<1500g) or gestational age of 32 weeks or less and infants weighing between 1500 and 2000g or gestational age of more than 32 weeks with an unstable clinical course. • Hearing loss screening of newborns provided by a participating hospital before discharge • 1 routine eye exam every 12 months through age 17 to determine the need for vision correction • 1 routine hearing exam every 24 months through age 17 to determine the need for hearing correction • Dietary and nutritional counseling for obesity - unlimited visits Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 1-888/238-6240 for information on whether a specific test is considered routine.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (see Section 5).
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	
Not covered: • *Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.*	*All charges*

Benefit Description	You pay
Dental Preventive Care	
Preventive care limited to: • Prophylaxis (cleaning of teeth – limited to 2 treatments per calendar year) • Fluoride applications (limited to 1 treatment per calendar year for children under age 16) • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing x-rays (one set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year) Participating network PPO dentists offer members services at a negotiated rate – so, you are generally charged less for your dental care when you visit a participating network PPO dentist. Refer to our DocFind® online provider directory at www.aetnafeds.com to find a participating network PPO dentist, or call Member Services at 1-888-238-6240.	In-network: Nothing at a network dentist Out-of-network: Nothing at a non-network dentist up to your available Dental Fund balance. However, you are responsible for non-network dentist fees that exceed our Plan allowance. See Section 5 Dental Fund.

Section 5. Medical and Dental Funds

Important things you should keep in mind about your Medical Fund benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- All eligible medical care expenses up to the Plan allowance in Section 5 (except in-network medical preventive care) are paid from your Medical Fund. Traditional medical coverage will start once your deductible is satisfied.
- Note that in-network medical preventive care covered under Section 5 does NOT count against your Medical Fund.
- The Medical Fund provides full coverage for eligible expenses from both in-network and non-network providers. However, your Medical Fund will generally go much further when you use network providers because network providers agree to discount their fees.
- You can track your Medical Fund on the Aetna Navigator website, by telephone at 1-888-238-6240 (toll-free), or, when you incur claims, with monthly statements mailed directly to you at home.
- Whenever you join this Plan, your annual Deductible will apply as of your effective date. The Plan will prorate the amount of the annual Medical Fund for members who join the Plan outside of the annual Open Season. If you join at any other time during the year, your Medical Fund for your first year will be prorated at a rate of $83 per month for Self Only or $167 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year. If your enrollment effective date falls between the first and fifteenth day of the month, you will be given credit as of the first of the month. If your enrollment effective date is the sixteenth or later in the month, you will be given credit as of the first of the following month.
- If a subscriber begins the year under Self Only enrollment and then switches to Self Plus One or Self and Family enrollment, the Medical Fund will increase from $1,000 to $2,000. We will deduct any amounts used while under the Self Only enrollment from the Self Plus One or Self and Family enrollment of $2,000.
- If the subscriber begins the year under Self Plus One or Self and Family enrollment and later switches to Self Only enrollment, the Medical Fund will decrease from $2,000 to $1,000. We will deduct amounts of the Medical Fund previously used while enrolled in the Self Plus One or Self and Family from the Self Only enrollment amount of $1,000. For example, if $650 of the Self and Family Medical Fund had been used and the subscriber changes to Self Only coverage, the Medical Fund will be $1,000 minus $650 or $350 for the balance of the year. Members will not be penalized for amounts used while in Self Plus One or Self and Family enrollment that exceed the amount of the Self Only Medical Fund.
- Medicare premium reimbursement – Medicare participating annuitants may request reimbursement for Medicare premiums paid if Medical Fund dollars are available. Please contact us at 1-888-238-6240 for more information.
- If you terminate your participation in this Plan, any remaining Medical Fund balance will be forfeited.
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR NON-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

Benefit Description	You pay
Medical fund	
A Medical Fund is provided by the Plan for each enrollment. Each year the Plan adds to your account. For 2016 the Medical Fund is: • $1,000 per year for a Self Only enrollment, or; • $2,000 per year for a Self Plus One or Self and Family enrollment. The Medical Fund covers eligible expenses at 100%. For example, if you are ill and go to a network doctor for a $75 visit, the doctor will submit your claim and the cost of the visit will be deducted automatically from your Medical Fund; you pay nothing. Balance in Medical Fund for Self Only $1,000 Less: Cost of visit - 75 Remaining Balance in Medical Fund $ 925 Medical Fund expenses are the same medical, surgical, hospital, emergency, mental health and substance abuse, and prescription drug services and supplies covered under the Traditional medical coverage (see Section 5 for details). To make the most of your Medical Fund, you should: • Use the network providers whenever possible; and • Use generic prescriptions whenever possible **Medical Fund Rollover** Provided you remain enrolled in the CDHP, any unused, remaining balance in your Medical Fund at the end of the calendar year may be rolled over to subsequent years. Note: This rollover feature can increase your Medical Fund in the following year(s) up to a maximum rollover of $5,000 Self Only enrollment or $10,000 Self Plus One or Self and Family enrollment. **Health Incentive Credit** The Plan will provide a health incentive credit for an enrollee or spouse who completes the Plan's "Simple Steps to a Healthier Life® Health Assessment", an online wellness program, and a post-program assessment. The post-program assessment becomes available to you 30 days after you complete the pre-program survey to enroll in the online wellness program. You have 30 days to complete the post-program assessment to earn your initial credit. The Plan will credit the Medical Fund $50 per enrollee and/or spouse up to an annual family limit of $100 upon completion of the health assessment, online wellness program, and post-program assessment.	In-network and out-of-network: Nothing up to your available Medical Fund balance. However, you are responsible for non-network medical fees that exceed our Plan allowance.

Medical fund - continued on next page

Benefit Description	You pay
Medical fund (cont.)	
Biometric Screening with Incentive The Plan will provide biometric screenings for members (over 18 years of age) with no cost sharing. Screenings must include total cholesterol, HDL, calculated LDL, calculated cholesterol/HDL ratio, triglycerides and glucose, blood pressure and waist circumference. The Plan will credit the member's medical fund with an incentive of $50 per enrollee and/or spouse, up to an annual family limit of $100 for biometric screening. Members obtain the screening at a Quest Diagnostics Patient Service Center (PSC). If you are not located within 20 miles of a Quest Diagnostics PSC, you may send the appropriate form to your physician's office and request that your physician complete the form and fax or mail it back to Quest. Visit www.aetnafeds.com for information on setting up an appointment at a Quest PSC or to obtain the form if you are not located within 20 miles of a Quest PSC. The biometric screening incentive is separate from the health incentive the Plan currently offers for completion of specific wellness activities	
Not covered: • *Non-network preventive care services not included under Section 5* • *Services or supplies shown as not covered under Traditional medical coverage (see Section 5)* • *Charges of non-network providers that exceed our Plan allowance.*	*All charges*

Dental Fund

Important things you should keep in mind about your Dental Fund benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Note that in-network preventive dental care covered under Section 5 does NOT count against your Dental Fund.
- Provided you remain enrolled in the CDHP, any unused, remaining balance in your Dental Fund at the end of the calendar year, will be rolled over to subsequent years.
- When you join this Plan, you will have access to the entire Dental Fund ($300 for Self Only, $600 for Self Plus One, or $600 for Self and Family) to share between you and your enrolled family members.
- Participating network PPO dentists offer members services at a negotiated rate – so, you are generally charged less for your dental care when you visit a participating network PPO dentist. Refer to our DocFind® online provider directory at www.aetnafeds.com to find a participating network PPO dentist, or call Member Services at 1-888-238-6240.
- All eligible dental expenses will be paid from your Dental Fund. You can track your Dental Fund on Aetna's Navigator website or by telephone at 1-888-238-6240. Note: Once your fund is exhausted, you may continue to save on the cost of your dental care with access to the discounted fees offered by participating network PPO dentists. Discounts may not be available in all states.
- If you are enrolled in a FEDVIP Dental Plan, the FEDVIP plan will pay first for dental services and your Dental Fund will pay second, except for diagnostic and preventive care. When you use an in-network provider, diagnostic and preventive care will be reimbursed at 100% and does not count against your Dental Fund. When you use a non-network dentist for these services, the Dental Fund will pay first and your FEDVIP plan will pay second. See page 41.
- You can visit any licensed dentist for covered services under the Dental Fund. However, you can make your Dental Fund go further by taking advantage of the negotiated rates offered by a participating network PPO dentist. These negotiated rates are generally less than the dentist's usual fees.
- **REMEMBER**: If you terminate your participation in this Plan, any Dental Fund balance you may have will be lost.

Benefit Description	You pay
Dental fund	
Dental Fund expenses include dental services up to a maximum of $300 for Self Only, $600 for Self Plus One or $600 for Self and Family enrollment. The Dental Fund covers eligible expenses at 100%. For example, if you go to a network dentist and incur charges of $125 for fillings, the dentist will submit your claim and the cost of the visit will be deducted automatically from your Dental Fund; you pay nothing. Balance in Dental Fund for Self Only $300 Less: Cost of fillings - 125 Remaining Balance in Dental Fund $175	Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance. Note: Once your Dental Fund is exhausted, you may pay the discounted fees offered by participating network PPO dentists. Discounts may not be available in all states. You are responsible for the full charges for services accessed from a non-network dentist.

Dental fund - continued on next page

Benefit Description	You pay
Dental fund (cont.)	
Dental Fund Rollover Provided you remain enrolled in the CDHP, any unused remaining balance in your Dental Fund at the end of the calendar year will be rolled over to subsequent years. Eligible dental covered services include:	Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance. Note: Once your Dental Fund is exhausted, you may pay the discounted fees offered by participating network PPO dentists. Discounts may not be available in all states. You are responsible for the full charges for services accessed from a non-network dentist.
Accidental injury benefit: We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance. Note: Once your Dental Fund is exhausted, you may pay the discounted fees offered by participating network PPO dentists. Discounts may not be available in all states. You are responsible for the full charges for services accessed from a non-network dentist.
Diagnostic and Preventive Care From Non-Network Dentists: • Prophylaxis (cleaning of teeth – limited to 2 treatments per calendar year) • Fluoride applications (limited to 1 treatment per calendar year for children under age 16) • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing x-rays (one set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year)	Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance. Note: Once your Dental Fund is exhausted, you may pay the discounted fees offered by participating network PPO dentists. Discounts may not be available in all states. You are responsible for the full charges for services accessed from a non-network dentist.
Restorative Care (Basic and Major) from Network or Non-Network Dentists: • Amalgam and resin-based composite restorations (“fillings”) • Inlays and onlays • Crowns • Fixed partial dentures (“bridgework”) • Root canal (“endodontics”) therapy, including necessary x-rays • Extractions (oral surgery) such as simple, surgical, soft tissue and bony impacted teeth • Osseous surgery (“periodontics”) - one per quadrant every 3 years, from the last date of service • General anesthesia and intravenous sedation	Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance. Note: Once your Dental Fund is exhausted, you may pay the discounted fees offered by participating network PPO dentists. Discounts may not be available in all states. You are responsible for the full charges for services accessed from a non-network dentist.

Dental fund - continued on next page

Benefit Description	You pay
Dental fund (cont.)	
• Repairs to removable partial dentures and complete dentures, within 6 months of installation • Occlusal guards (for bruxism only) – limited to one every 3 years, from the last date of service	Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance. Note: Once your Dental Fund is exhausted, you may pay the discounted fees offered by participating network PPO dentists. Discounts may not be available in all states. You are responsible for the full charges for services accessed from a non-network dentist.
Not covered: • *Orthodontia* • *Dental treatment for cosmetic purposes* • *Dental care involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome* • *Dental implants* • *Replacement of crowns, fixed partial dentures (bridges), removable partial dentures or complete dentures, if the existing crown, fixed partial denture (bridge), removable partial denture or complete denture was originally placed less than 8 years prior to the replacement.* • *Charges of non-network providers that exceed our Plan allowance*	*All charges*

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your deductible is $1,000 for Self Only enrollment, $2,000 for Self Plus One enrollment, and $2,000 for Self and Family enrollment. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Your Medical Fund ($1,000 Self Only enrollment, $2,000 for Self Plus One enrollment, and $2,000 for Self and Family enrollment) and any rollover funds from prior years must be used first for eligible health care expenses.
- Traditional medical coverage does not begin until you have used your Medical Fund and satisfied your deductible.
- Prescription drug benefits change to a copayment level once you satisfy your deductible. See section 5(f).
- In-network medical preventive care is covered at 100% under Section 5 and does not count against your Medical Fund.
- The Medical Fund provides coverage for both in-network and non-network providers. Under the Traditional medical coverage, in-network benefits apply only when you use a network provider. Out-of-network benefits apply when you do not use a network provider.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR NON-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

Benefit Description	You pay After the calendar year deductible…
Your deductible before Traditional medical coverage begins	
Once your Medical Fund has been exhausted, you must satisfy your deductible before your Traditional medical coverage begins. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. Once your deductible is satisfied, you will be responsible for your coinsurance amounts for eligible medical expenses until you meet the annual catastrophic out-of-pocket maximum. You also are responsible for copayments for eligible prescriptions.	100% of allowable charges until you meet the deductible of $1,000 per Self Only enrollment, $2,000 per Self Plus One enrollment, or $2,000 per Self and Family enrollment.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your deductible is $1,000 for Self Only, $2,000 per Self Plus One enrollment, and $2,000 for Self and Family enrollment. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians • In physician's office - Office medical evaluations, examinations and consultations - Second surgical or medical opinion - Initial examination of a newborn child covered under a Self Plus One or Self and Family enrollment • In an urgent care center for a routine service • During a hospital stay • In a skilled nursing facility • At home	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Teladoc consult Please see www.aetnafeds.com for information on Teladoc service. Note: Members will receive a Teladoc welcome kit explaining the benefit Note: Teladoc is not available for service in Missouri, Idaho and Arkansas	In-network: $40 per consult until the deductible is met, 15% of the $40 consult fee thereafter. Out-of-network: No benefit. Members must use a Teladoc provider.
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests (cont.)	
• CAT Scans/MRI* • Ultrasound • Electrocardiogram and electroencephalogram (EEG) * Note: CAT Scans and MRIs require precertification, see "Services requiring our prior approval" on pages 24-25.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Genetic Counseling and Evaluation for BRCA Testing • Genetic Testing for BRCA-Related Cancer* *Note: Requires precertification. See "Services requiring our prior approval" on pages 24-25.	In-network: Nothing at a network provider Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care - includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk, • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits and Surgery benefits.	In-network: No coinsurance for prenatal care or the first postpartum care visit, 15% of our Plan allowance for postpartum care visits thereafter when services are rendered by an in-network delivering health care provider. Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Breastfeeding support, supplies and counseling for each birth	In-network: Nothing at a network provider. Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Home births	*All charges*

Benefit Description	You pay After the calendar year deductible…
Family planning	
A range of voluntary family planning services limited to: • Contraceptive counseling on an annual basis • Voluntary sterilization (See Surgical procedures) • Surgically implanted contraceptives • Generic injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms Note: We cover injectable contraceptives under the medical benefit when supplied by and administered at the provider's office. Injectable contraceptives are covered at the prescription drug benefit when they are dispensed at the Pharmacy. If a member must obtain the drug at the pharmacy and bring it to the provider's office to be administered, the member would be responsible for both the Rx and office visit cost shares. We cover oral contraceptives under the prescription drug benefit.	In-network: Nothing for women For men: In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Reversal of voluntary surgical sterilization, genetic counseling	*All charges*
Infertility services	
Infertility is a disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (6 months for women age 35 or older). • Testing for diagnosis and surgical treatment of the underlying cause of infertility.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Any assisted reproductive technology (ART) procedure or services related to such procedures, including but not limited to in-vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection or* • *Artificial Insemination and monitoring of ovulation:* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI) or* • *Any changes associated with care required to obtain ART services (e.g. office, hospital, ultrasounds, laboratory tests, etc); and any charges associated with obtaining sperm for any ART procedures.* • *Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services* • *Services and supplies related to the above mentioned services, including sperm processing* • *Services associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g. office, hospital, ultrasounds, laboratory tests etc.)*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	
• *The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;* • *Reversal of sterilization surgery.* • *Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal* • *Injectable fertility drugs, including but not limited to menotropins, hCG, GnRH agonists, and IVIG* • *Infertility treatment when the FSH level is 19 mIU/ml or greater on day 3 of menstrual cycle* • *Cost of home ovulation predictor kits or home pregnancy kits* • *Drugs related to the treatment of non-covered benefits* • *Infertility services that are not reasonably likely to result in success*	*All charges*
Allergy care	
• Testing and treatment • Allergy injection • Allergy serum	In-network: 15% of our Plan allowance, nothing for serum Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 62. • Respiratory and inhalation therapy • Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy — Home IV and antibiotic therapy must be precertified by your attending physician. • Growth hormone therapy (GHT) Note: We cover growth hormone injectables under the prescription drug benefit.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	
Note: We will only cover GHT when we preauthorize the treatment. Call 1-888/238-6240 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and it is authorized by Aetna. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Applied Behavioral Analysis (ABA)	*All charges*
Physical and occupational therapies	
• 60 visits per person, per calendar year for physical or occupational therapy, or a combination of both for the services of each of the following: - Qualified Physical therapists - Occupational therapists Note: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient therapy is covered under Hospital/ Extended Care Benefits. • Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome Note: Physical therapy treatment of lymphedemas following breast reconstruction surgery is covered under the Reconstructive surgery benefit - see section 5(b).	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Long-term rehabilitative therapy*	*All charges*
Pulmonary and cardiac rehabilitation	
• 20 visits per condition per member per calendar year for pulmonary rehabilitation to treat functional pulmonary disability. • Cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or a myocardial infarction is provided for up to 3 visits a week for a total of 18 visits.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Long-term rehabilitative therapy	*All charges*
Habilitative Services	
Habilitative services for children under age 19 with congenital or genetic birth defects including, but not limited to, autism or an autism spectrum disorder, and cerebral palsy. Treatment is provided to enhance the child's ability to function. Services include occupational therapy, physical therapy and speech therapy. Note: See Occupational therapy, physical therapy and speech therapy for plan coverage and limitations.	In-network: 15%of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible…
Speech therapy	
• 60 visits per person, per calendar year.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Hearing services (testing, treatment, and supplies)	
• Hearing exams for children through age 17 (*as shown in Preventive Care, children*) • One hearing exam every 24 months (See In-network Medical Preventive Care, adult) • Audiological testing and medically necessary treatments for hearing problems Note: Discounts on hearing exams, hearing services, and hearing aids are also available. Please see the Non-FEHB Benefits section of this brochure for more information.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *All other hearing testing and services that are not shown as covered* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Treatment of eye diseases and injury	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• One routine eye exam (including refraction) every 12-month period (See In-Network Medical Preventive Care)	In-network: Nothing Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Corrective eyeglasses and frames or contact lenses (hard or soft).	Nothing up to your available Medical Fund balance. All charges if Medical Fund balance is exhausted. Not subject to deductible.
Not Covered: • *Corrective eyeglasses and frames or contact lenses (except as above)* • *Fitting of contact lenses* • *Vision therapy, including eye patches and eye exercises, e.g., orthoptics, pleoptics, for the treatment of conditions related to learning disabilities or developmental delays* • *Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open manipulation or fixation)* • *Foot orthotics* • *Podiatric shoe inserts*	*All charges*
Orthopedic and prosthetic devices	
• Orthopedic devices such as braces and corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and prosthetic devices such as artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), surgically implanted breast implant following mastectomy, and lenses following cataract removal. See Surgical section 5(b) for coverage of the surgery to insert the device. • Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.)	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Hair prosthesis prescribed by a physician for hair loss resulting from radiation therapy, chemotherapy or certain other injuries, diseases, or treatment of a disease. Note: Plan lifetime maximum of $500.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Orthopedic and corrective shoes not attached to a covered brace* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Penile implants* • *All charges over $500 for hair prosthesis*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Contact Plan at 1-888/238-6240 for specific covered DME. Some covered items include: • Oxygen • Dialysis equipment • Hospital beds (Clinitron and electric beds must be preauthorized) • Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Insulin pumps and related supplies such as needles and catheters • Certain bathroom equipment such as bathtub seats, benches and lifts Note: Some DME may require precertification by you or your physician.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Home modifications such as stair glides, elevators and wheelchair ramps* • *Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities*	*All charges*
Home health services	
• Home health services ordered by your attending Physician and provided by nurses and home health aides through a home health care agency. Home health services include skilled nursing services provided by a licensed nursing professional; services provided by a physical therapist, occupational therapist, or speech therapist, and services of a home health aide when provided in support of the skilled home health services. Home health services are limited to 3 visits per day with each visit equal to a period of 4 hours or less. Your attending physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications. Note: Skilled nursing under Home health services must be precertified by your attending Physician.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Nursing care for the convenience of the patient or the patient's family.* • *Transportation* • *Custodial care, i.e., home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative, and appropriate for the active treatment of a condition, illness, disease or injury.* • *Services of a social worker*	*All charges*

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Home health services (cont.)	
• *Services provided by a family member or resident in the member's home.* • *Services rendered at any site other than the member's home.* • *Services rendered when the member is not homebound because of illness or injury.* • *Private duty nursing services.*	*All charges*
Chiropractic	
• Chiropractic - services up to 20 visits per member per calendar year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electric muscle stimulation, vibratory therapy and cold pack application	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Any services not listed above*	*All charges*
Alternative medicine treatments	
Acupuncture - when provided as anesthesia for covered surgery Note: See page 68 for our coverage of acupuncture when provided as anesthesia for covered surgery. See Section 5 Non-FEHB benefits available to Plan members for discount arrangements.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Other alternative medical treatments including but not limited to: • *Acupuncture other than stated above* • *Applied kinesiology* • *Aromatherapy* • *Biofeedback* • *Craniosacral therapy* • *Hair analysis* • *Reflexology*	*All charges*
Educational classes and programs	
Aetna Health Connections offers disease management for 34 conditions. Included are programs for: • Asthma • Cerebrovascular disease • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Coronary artery disease • Cystic Fibrosis • Depression • Diabetes	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…
Educational classes and programs (cont.)	
• Hepatitis • Inflammatory bowel disease • Kidney failure • Low back pain • Sickle cell disease To request more information on our disease management programs, call 1-888/238-6240.	Nothing
Coverage is provided for: • Tobacco Cessation Programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Note: OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	In-network: Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence. Out-of-network: Nothing up to our Plan allowance for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing up to our Plan allowance for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence.
Not covered: *Applied Behavioral Analysis (ABA)*	*All charges*

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your deductible is $1,000 for Self Only, $2,000 for Self Plus One, and $2,000 for Self and Family enrollment. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual has a body mass index (BMI) exceeding 40 or a BMI greater than 35 in conjunction with documented significant co-morbid conditions (such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea or refractory hypertension). - Eligible members must be age 18 or over or have completed full growth.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
- Members must complete a physician-supervised nutrition and exercise program within the past two years for a cumulative total of six months or longer in duration, with participation in one program for at least three consecutive months, prior to the date of surgery documented in the medical record by an attending physician who supervised the member's participation; or member participation in an organized multidisciplinary surgical preparatory regimen of at least three months duration proximate to the time of surgery. - For members who have a history of severe psychiatric disturbance or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary. **We will consider:** - Open or laparoscopic Roux-en-Y gastric bypass; or - Open or laparoscopic biliopancreatic diversion with or without duodenal switch; or - Sleeve gastrectomy; or - Laparoscopic adjustable silicone gastric banding (Lap-Band) procedures. • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization for men (e.g., vasectomy) • Treatment of burns • Skin grafting and tissue implants • Gender reassignment surgery* - The Plan will provide coverage for the following when the member meets Plan criteria: • Surgical removal of breasts for female-to-male patients • Surgical removal of uterus and ovaries in female-to-male and testes in male-to-female • Reconstruction of external genitalia** *Subject to medical necessity ** Note: Requires Precertification. See "Services requiring our prior approval" on pages 24-25. You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 1-888/238-6240.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Voluntary sterilization for women (e.g., tubal ligation)	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
Not covered: • *Reversal of voluntary surgically-induced sterilization* • *Surgery primarily for cosmetic purposes* • *Radial keratotomy and laser surgery, including related procedures designed to surgically correct refractive errors* • *Routine treatment of conditions of the foot; see Foot care* • *Gender reassignment services that are not considered medically necessary*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital and developmental anomalies are cleft lip, cleft palate, webbed fingers, and webbed toes. All surgical requests must be preauthorized. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedema - breast prostheses and surgical bras and replacements (*see Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form and for which the disfigurement is not associated with functional impairment, except repair of accidental injury*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery	
Oral surgical procedures, that are medical in nature, such as: • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ (must be preauthorized); and • Excision of tumors and cysts. Note: When requesting oral and maxillofacial services, please check DocFind or call Member Services at 1-888-238-6240 for a participating oral and maxillofacial surgeon.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Dental implants* • *Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on pages 24-25. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitisCornea • Heart • Heart/lung • Intestinal Transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas; Pancreas/Kidney (simultaneous)	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. - Autologous tandem transplants for: • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer)	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)* - Hemoglobinopathies - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Ependymoblastoma - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors *Approved clinical trial necessary for coverage.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Sarcomas - Sickle Cell anemia • Autologous Transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Breast cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• **National Transplant Program (NTP) -** Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your primary care doctor and plan specialist physician and approved by our medical director in advance of the surgery. To receive in-network benefits the transplant must be performed at hospitals (Institutes of Excellence) specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.	
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four allogenic bone marrow/stem cell transplant donors in addition to the testing of family members.	

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Clinical trials must meet the following criteria: A. The member has a current diagnosis that will most likely cause death within one year or less despite therapy with currently accepted treatment; or the member has a diagnosis of cancer; AND B. *All* of the following criteria must be met: 1. Standard therapies have not been effective in treating the member or would not be medically appropriate; and 2. The risks and benefits of the experimental or investigational technology are reasonable compared to those associated with the member's medical condition and standard therapy based on at least two documents of medical and scientific evidence (as defined below); and 3. The experimental or investigational technology shows promise of being effective as demonstrated by the member's participation in a clinical trial satisfying ALL of the following criteria: a. The experimental or investigational drug, device, procedure, or treatment is under current review by the FDA and has an Investigational New Drug (IND) number; and b. The clinical trial has passed review by a panel of independent medical professionals (evidenced by Aetna's review of the written clinical trial protocols from the requesting institution) approved by Aetna who treat the type of disease involved and has also been approved by an Institutional Review Board (IRB) that will oversee the investigation; and c. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national cooperative body (e.g., Department of Defense, VA Affairs) and conforms to the rigorous independent oversight criteria as defined by the NCI for the performance of clinical trials; and d. The clinical trial is not a single institution or investigator study (NCI designated Cancer Centers are exempt from this requirement); and 4. The member must: a. Not be treated "off protocol," and b. Must actually be enrolled in the trial.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials. Terminal illness means a medical prognosis of 6 months or less to live); and* • *Costs of data collection and record keeping that would not be required but for the clinical trial; and* • *Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs"); and*	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• *Items and services provided by the trial sponsor without charge* • *Donor screening tests and donor search expenses, except as shown* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services (including Acupuncture - when provided as anesthesia for a covered surgery) provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your deductible is $1,000 for Self Only, $2,000 for Self Plus One, and $2,000 for Self and Family enrollment. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR NON-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as • Private, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, Immunoglobulin, and prolastin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	
• Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Whole blood and concentrated red blood cells not replaced by the member* • *Non-covered facilities, such as nursing homes, schools* • *Custodial care, rest cures, domiciliary or convalescent cares* • *Personal comfort items, such as telephone and television* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Radiologic procedures, diagnostic laboratory tests, and X-rays when associated with a medical procedure being done the same day • Pathology Services • Administration of blood, blood plasma, and other biologicals • Blood products, derivatives and components, artificial blood products and biological serum • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), penile implants, defibrillator, surgically implanted breast implant following mastectomy, and lenses following cataract removal. Note**:** We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Note: In-network preventive care services are not subject to coinsurance listed.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Whole blood and concentrated red blood cells not replaced by the member.	*All charges*

Benefit Description	You pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 60-day limit per calendar year when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Custodial care	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of your attending Physician, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less. Note: Inpatient hospice services require prior approval.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Ambulance	
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency* • *Ambulette service* • *Ambulance transportation for member convenience or reasons that are not medically necessary* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your deductible is $1,000 for Self Only, $2,000 for Self Plus One, and $2,000 for Self and Family enrollment. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency: If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify Aetna as soon as possible.

Benefit Description	You pay After the calendar year deductible…
Emergency	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services	In-network: 15% of our Plan allowance Out-of-network: 15% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Elective care or non-emergency care	*All charges*
Ambulance	
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or	In-network: 15% of our Plan allowance Out-of-network: 15% of our Plan allowance and any difference between our allowance and the billed amount.

Ambulance - continued on next page

Benefit Description	You pay After the calendar year deductible…
Ambulance (cont.)	
3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member. Note: Air ambulance may be covered. Prior approval is required.	In-network: 15% of our Plan allowance Out-of-network: 15% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency.* • *Ambulette service.* • *Air ambulance without prior approval.* • *Ambulance transportation for member convenience or for reasons that are not medically necessary.* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for certain services.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins.
- Your deductible is $1,000 for Self Only, $2,000 for Self Plus One, and $2,000 for Self and Family enrollment. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. Preauthorization is required for the following:
  - Any intensive outpatient care (minimum of two (2) hours per day or six (6) hours per week - can include group, individual, family or multi-family group psychotherapy, etc.)
  - Outpatient detoxification
  - Partial hospitalization
  - Any inpatient or residential care
  - Psychological or neuropsychological testing
  - Outpatient electroconvulsive therapy
  - Biofeedback and amytal interview
  - Psychiatric home health care
- Aetna can assist you in locating participating providers in the Plan, unless your needs for covered services extend beyond the capability of the affiliated providers. Emergency care is covered (See Section 5(d), Emergency services/accidents). You can receive information regarding the appropriate way to access the behavioral health care services that are covered under your specific plan by calling Member Services at 1-888/238-6240. A referral from your PCP is not necessary to access behavioral health care but your PCP may assist in coordinating your care.
- We will provide medical review criteria for denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes on medically necessary clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility including an overnight residential treatment facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility including an overnight residential treatment facility • Services in approved treatment programs, such as partial hospitalization, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible…
Not covered	
• *Educational services for treatment of behavioral disorders* • *Services in half-way houses* • *Applied Behavioral Analysis (ABA)*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- This is a five tier open formulary pharmacy plan. A formulary is a list of generic and brand-name drugs that your health plan covers. Each drug is associated with a tier on the formulary list. Tier-one is generic drugs on our formulary list, Tier-two is brand name drugs on our formulary list, Tier-three is drugs not on our formulary list, Tier-four is preferred specialty drugs and Tier-five is non-preferred specialty drugs. Each tier has a separate out-of-pocket cost.
- We cover prescribed drugs and medications, as described in the chart beginning on the third page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Your deductible is $1,000 for Self Only, $2,000 for Self Plus One, and $2,000 for Self and Family enrollment. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Your Medical Fund **must** be used first for eligible pharmacy expenses and your deductible must be satisfied before your Traditional medical coverage begins. The cost of your prescription will be deducted from your Medical Fund, if available, at the time of the purchase. The cost of your prescription is based on the Aetna contracted rate with network pharmacies. The Aetna contracted rate with the network pharmacy does not reflect or include any rebates Aetna receives from drug manufacturers.
- Once you exhaust the Medical Fund and satisfy the deductible, you will then pay a copayment at in-network retail pharmacies or the mail-order pharmacy for prescriptions under your Traditional medical coverage. You will pay 40% coinsurance plus the difference between our Plan allowance and the billed amount at out-of-network retail pharmacies. There is no out-of-network mail order pharmacy program.
- Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Upon approval by the Plan, the prescription is covered for the current calendar year or a specified time period, whichever is less.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of which include:

- **Who can write your prescription.** A licensed physician or dentist and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** Any retail pharmacy can be used for up to a 30-day supply. Our mail order program must be utilized for a 31-day up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay (retail pharmacy), and for a 31-day up to a 90-day supply of medication for two copays (mail order). For retail pharmacy transactions, you must present your Aetna Member ID card at the point of sale for coverage. Please call Member Services at 1-888-238-6240 for more details on how to use the mail order program. **Mail order is not available for drugs and medications ordered through Aetna Specialty Pharmacy. Prescriptions ordered through Aetna Specialty Pharmacy are only filled for up to a 30-day supply due to the nature of these prescriptions.** If accessing a nonparticipating pharmacy, the member must pay the full cost of the medication at the point of service, then submit a complete paper claim and a receipt for the cost of the prescription to our Direct Member Reimbursement (DMR) unit. Reimbursements are subject to review to determine if the claim meets applicable requirements, and are subject to the terms and conditions of the benefit plan and applicable law.
- **We use a formulary.** Drugs are prescribed by licensed attending doctors and covered in accordance with the Plan's drug formulary; however, coverage is not limited to medications included on the formulary. Many non-formulary drugs are also covered but a higher copayment will apply. Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Visit our website at www.aetnafeds.com to review our Formulary Guide or call 1-888-238-6240.

- **Drugs not on the formulary.** Aetna has a Pharmacy and Therapeutics Committee, comprised of physicians, pharmacists and other clinicians that review drugs for inclusion in the formulary. They consider the drug's effectiveness, safety and cost in their evaluation. While most of the drugs on the non-formulary list are brand drugs, some generic drugs also may be on the non-formulary list. For example, this may happen when brand medications lose their patent and the FDA has granted a period of exclusivity to specific generic manufacturers. When this occurs, the price of the generic drug may not decrease as you might think most generic drugs do. This period of exclusivity usually ranges between 3-6 months. Once this time period expires, competition from other generic manufacturers will generally occur and this helps lower the price of the drug and this may lead Aetna to re-evaluate the generic for possible inclusion on the formulary. Aetna will place some of these generic drugs that are granted a period of exclusivity on our non-formulary list, which requires the highest copay level. **Remember, a generic equivalent will be dispensed, if available, unless your physician specifically requires a brand name and writes "Dispense as Written" (DAW) on the prescription, so discuss this with your doctor.**
- **Choose generics.** The Plan requires the use of generics if a generic drug is available. If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained from the Plan. Generics contain the same active ingredients in the same amounts as their brand name counterparts and have been approve by the FDA. By using generic drugs, you will see cost savings, without jeopardizing clinical outcome or compromising quality.
- **Precertification.** Your pharmacy benefits plan includes our precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by our Pharmacy Management Precertification Unit before they will be covered. Only your physician or pharmacist, in the case of an antibiotic or analgesic, can request prior authorization for a drug. Step-therapy is another type of precertification under which certain medications will be excluded from coverage unless you try one or more "prerequisite" drug(s) first, or unless a medical exception is obtained. The drugs requiring precertification or step-therapy are subject to change. Visit our website at www. aetnafeds.com for the most current information regarding the precertification and step-therapy lists. Ask your physician if the drugs being prescribed for you require precertification or step therapy.
- **When to use a participating retail or mail order pharmacy.** Covered prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy may be dispensed for up to a 30-day supply. Members must obtain a 31-day up to a 90-day supply of covered prescription medication through mail order (applies to in-network pharmacies only). In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available, unless your physician specifically requires a brand name. Drug costs are calculated based on Aetna's contracted rate with the network pharmacy excluding any drug rebates. While Aetna Rx Home Delivery is most likely the most cost effective option for most prescriptions, there may be some instances where the most cost effective option for members will be to utilize a retail pharmacy for a 30 day supply versus Aetna Rx Home Delivery. Members should utilize the Cost of Care Tool prior to ordering prescriptions through mail order (Aetna Rx Home Delivery) to determine the cost.

  In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filing of their medication(s) prior to departure, their pharmacist will need to contact Aetna. Coverage of additional prescriptions will only be allowed if there are refills remaining on the member's current prescription or a new prescription has been issued by their physician. The member is responsible for the applicable copayment for the additional prescription.
- Aetna allows coverage of a medication filling when at least 80% of the previous prescription according to the physician's prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a new prescription to be covered on the 23rd day, thereby allowing a member to have an additional supply of their medication, in case of emergency.
- **When you do have to file a claim.** Send your itemized bill(s) to: Aetna, Pharmacy Management, P.O. Box 52444, Phoenix, AZ 85072-2444.

Here are some things to keep in mind about our prescription drug program:

- A generic equivalent may be dispensed if it is available, and where allowed by law.
- **Specialty drugs.** Specialty drugs are medications that treat complex, chronic diseases. Our specialty drug program is called Aetna Specialty CareRx, which includes select oral, injectable and infused medications. Because of the complex therapy needed, a pharmacist or nurse should check in with you often during your treatment. The first fill of these medications can be obtained through a participating retail pharmacy or specialty pharmacy. However, you must obtain all subsequent refills through a participating specialty pharmacy such as Aetna Specialty Pharmacy.

Certain Aetna Specialty CareRx medications identified with a (+) next to the drug name may be covered under the medical or pharmacy section of this brochure depending on how and where the medication is administered.

Often these drugs require special handling, storage and shipping. In addition, these medications are not always available at retail pharmacies. For a detailed listing of what medications fall under your Aetna Specialty CareRx benefit please visit: www.AetnaSpecialtyCareRx.com. You can also visit www.aetnafeds.com for the 2016 Aetna Specialty CareRx list or contact us at 1-888/238-6240 for a copy. Note that the medications and categories covered are subject to change.

- To request a printed copy of the Aetna Preferred Drug (Formulary) Guide, call 1-888-238-6240. The information in the Aetna Preferred Drug (Formulary) Guide is subject to change. As brand name drugs lose their patents and the exclusivity period expires, and new generics become available on the market, the brand name drug may be removed from the formulary. Under your benefit plan, this will result in a savings to you, as you pay a lower prescription copayment for generic formulary drugs. Please visit our website at www.aetnafeds.com for current Aetna Preferred Drug (Formulary) Guide information.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by your licensed attending physician or dentist and obtained from a Plan pharmacy or through our mail order program or an out-of-network retail pharmacy:	**In-network:** The full cost of the prescription is applied to the deductible before any benefits are considered for payment under the pharmacy plan. Once the deductible is satisfied, the following will apply:
• Drugs and medicines approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as *Not Covered* • Self-injectable drugs • Diabetic supplies limited to lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips • Insulin • Disposable needles and syringes for the administration of covered medications Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/ coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered generic formulary drug; $35 per covered brand name formulary drug; and $75 per covered non-formulary (generic or brand name) drug. Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 per covered generic formulary drug $70 per covered brand name formulary drug; and $150 per covered non-formulary (generic or brand name) drug. **Out-of-network (retail pharmacies only):** 40% plus the difference between our Plan allowance and the billed amount.
We cover the following medications based on the US Preventive Services Task Force A and B recommendations. A prescription is required and must be processed through our pharmacy claim system. • Aspirin for adults age 45 and older (325 mg in strength or less) • Iron supplementation for children ages 6 to 12 months • Oral fluoride for children ages 6 months through age 5 • Vitamin D for adults age 65 and older • Folic acid supplementation for females	**In-network:** Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
Women's contraceptive drugs and devices • Generic oral contraceptives on our formulary list • Generic emergency contraception, including OTC when filled with a prescription • Generic injectable contraceptives on our formulary list - 5 vials per calendar year • Diaphragms - 1 per calendar year	**In-network:** Nothing **Out-of-network (retail pharmacies only):** 40% plus the difference between our Plan allowance and the billed amount.
• Brand name contraceptive drugs • Brand name injectable contraceptive drugs such as Depo Provera - 5 vials per calendar year • Brand emergency contraception	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $35 per covered brand name formulary drug; and $75 per covered non-formulary (generic or brand name) drug. Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $70 per covered brand name formulary drug; and $150 per covered non-formulary (generic or brand name) drug. **Out-of-network (retail pharmacies only):** 40% plus the difference between our Plan allowance and the billed amount.
Specialty Medications **Specialty medications must be filled through a specialty pharmacy such as Aetna Specialty Pharmacy**. These medications are not available through the mail order benefit. Certain Aetna Specialty CareRx medications identified with a (+) next to the drug name may be covered under the medical or pharmacy section of this brochure. Please refer to page 78, Specialty Drugs for more information or visit: www.AetnaSpecialtyCareRx.com.	Up to a 30-day supply per prescription or refill: Preferred: 50% up to a $250 maximum Non-preferred: 50% up to $500 maximum
Limited benefits: • Drugs to treat erectile dysfunction are limited up to 4 tablets per 30-day period. • Imitrex (limited to 48 kits per calendar year) Note: Mail order is not available	**In-network:** Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered generic formulary drug; $35 per covered brand name formulary drug; and $75 per covered non-formulary (generic or brand name) drug. **Out-of-network (retail pharmacies only):** 40% plus the difference between our Plan allowance and the billed amount.

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
Not covered: - *Drugs used for the purpose of weight reduction, such as appetite suppressants* - *Drugs for cosmetic purposes, such as Rogaine* - *Drugs to enhance athletic performance* - *Medical supplies such as dressings and antiseptics* - *Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug) unless required by law* - *Lost, stolen or damaged drugs* - *Vitamins (including prescription vitamins), nutritional supplements, and any food item, including infant formula, medical foods and other nutritional items, even if it is the sole source of nutrition unless otherwise stated* - *Prophylactic drugs including, but no limited to, anti-malarials for travel* - *Fertility drugs* - *Compounded bioidentical hormone replacement (BHR) therapy that includes progesterone, testosterone and/or estrogen* - *Compounded thyroid hormone therapy* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit. (See page 58). OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	*All charges*

Value Plan Benefits

See pages 154-155 for a benefits summary.

Section 5. Value Plan Benefits Overview

This Plan offers a Value option. Our benefit package is described in this Section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

Value Plan Section 5, which describes the Value Plan benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the general exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about Value Plan benefits, contact us at 1-888/238-6240 or on our website at www.aetnafeds.com.

With this Plan, in-network preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 90.

- **Catastrophic protection for out-of-pocket expenses**

  Your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,000 for Self Only, $6,850 for Self Plus One, or $6,850 for Self and Family enrollment in-network and $5,000 for Self Only, $10,000 for Self Plus One, or $10,000 for Self and Family enrollment out-of-network. The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and Value Section 5 *Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

  Connect to www.aetnafeds.com for access to Aetna Navigator, a secure and personalized member site offering you a single source for health and benefits information. Use it to:

  - Perform self-service functions, like checking your deductible balance or the status of a claim.

  Aetna Navigator gives you direct access to:

  - Personal Health Record that provides you with online access to your personal health information including health care providers, drug prescriptions, medical tests, individual personalized messages, alerts and a detailed health history that can be shared with your physicians.
  - Cost of Care tools that compare in-network and out-of-network provider fees, the cost of brand-name drugs vs. their generic equivalents, and the costs for services such as routine physicals, emergency room visits, lab tests, X-rays, MRIs, etc.
  - Member Payment Estimator that provides real-time, out-of-pocket estimates for medical expenses based on your Aetna health plan. You can compare the cost of doctors and facilities before you make an appointment, helping you budget for and manage health care expenses.
  - A hospital comparison tool that allows you to see how hospitals in your area rank on measures important to your care.
  - Our DocFind® online provider directory.
  - Online customer service that allows you to request member ID cards, send secure messages to Member Services, and more.
  - Healthwise® Knowledgebase where you get information on thousands of health-related topics to help you make better decisions about your health care and treatment options.

- **Health Incentive Credit and Biometric Screening Incentive**

Health Incentive Credit: The Plan will provide a health incentive credit of up to $150 for Self Only, $300 for Self Plus One or $300 for Self and Family for completing any combination of the activities listed below. Each activity below allows a member to earn a $50 credit for completion, up to the maximum incentive credit of $150 for Self Only, $300 for Self Plus One or $300 for Self and Family.

- Online health risk assessment, one online wellness program and a post program assessment
- Routine mammogram
- Well adult preventive care (includes well adult visits, Prostate Specific Antigen (PSA) test, routine hearing exam and routine x-ray)
- Well baby/well child preventive care
- Immunizations
- Flu Shot
- Well woman preventive care (includes routine Ob/Gyn and routine Pap/Radiologist/ Pathologist and Lab)
- Routine eye exam

All services listed above must be covered services and can be subject to frequency limitations.

Biometric Screening Incentive: (Available February 1st - December 31st due to tracking requirements) The Plan will provide a health incentive credit for an enrollee and spouse (over 18 years of age) who complete a biometric screening. Screenings must include total cholesterol, HDL, calculated LDL, calculated cholesterol/HDL ratio, triglycerides and glucose, blood pressure, and waist circumference.

Members obtain the screening at a Quest Diagnostics Patient Service Center (PSC). If you are not located within 20 miles of a Quest Diagnostics PSC, you may send the appropriate form to your physician's office, and request that your physician complete the form and fax or mail it back to Quest. The Plan will provide a credit of $50 per enrollee and/or spouse, up to an annual family limit of $100.

Visit www.aetnafeds.com for information on setting up an appointment at a Quest PSC or to obtain the form if you are not located within 20 miles of a Quest PSC.

Credits earned from the Health Incentive Credit and Biometric Screening Incentive will offset future claims. Any new claims submitted after credits are earned will be paid first with any accumulated credits. The incentive credit will offset the deductible and coinsurance, not any other kind of member responsibility (such as copays). Credits also cannot be used toward pharmacy copays or coinsurance.

The following is an example of how the credits would work:

A member completes two of the activities above and earns $100 in credits. The member then receives services and the charge is $67. The member has not yet met their deductible. The provider will submit the claim to Aetna and Aetna would pay the $67 using the member's credit. Member would owe nothing to the provider and would still have a $33 credit to use toward another claim. The $67 would still apply to the member's deductible. Any unused credits carry over year to year as long as the member continues in that plan.

Members can view their credit balance on Aetna Navigator. Once logged in, click on "View Incentives."

Section 5. Medical Preventive Care

Important things you should keep in mind about these medical preventive care benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Preventive care is health care services designed for prevention and early detection of illness in average risk, people without symptoms, generally including routine physical examinations, tests and immunizations. We follow the U.S. Preventive Services Task Force recommendations for preventive care unless noted otherwise. For more information visit www.aetnafeds.com.
- The Plan pays 100% for the medical preventive care services listed in this Section as long as you use a network provider.
- If you choose to access preventive care from a non-network provider, you will not qualify for 100% preventive care coverage. Please see Section 5 – Traditional medical coverage subject to the deductible.
- For preventive care not listed in this Section, preventive care from a non-network provider, or any other covered expenses, please see Section 5 – Traditional medical coverage subject to the deductible.

Benefit Description	You pay
Medical Preventive Care, adult	
Routine screenings, such as: • Blood tests • Routine urine tests • Total Blood Cholesterol • Fasting lipid profile • Routine Prostate Specific Antigen (PSA) test — one annually for men age 40 and older • Colorectal Cancer Screening, including: - Fecal occult blood test yearly starting at age 50 - Sigmoidoscopy screening — every five years starting at age 50 - Colonoscopy screening — every 10 years starting at age 50 • Lung Cancer Screening - 1 screening annually from age 55 and over Note: Physician consultation for colorectal screening visits prior to the procedure are not considered preventive. • Abdominal Aortic Aneurysm Screening – Ultrasonography, one screening for men age 65 and older • Dietary and nutritional counseling for obesity - 26 visits annually • Routine annual digital rectal exam (DRE) for men age 40 and older	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount.
Well woman care including, but not limited to:	In-network: Nothing at a network provider.

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay
Medical Preventive Care, adult (cont.)	
• Routine well woman exam (one visit per calendar year) • Routine Pap test • Human Papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immune-deficiency virus. • Generic contraceptive methods and counseling. (See page 122) • Screening and counseling for interpersonal and domestic violence.	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Routine mammogram - covered for women age 35 and older, as follows: - From age 35 through 39, one during this five year period - From age 40 to 64, one every calendar year - At age 65 and older, one every 2 consecutive calendar years	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Routine physicals: - One exam every 2 calendar years up to age 65 - One exam every calendar year age 65 and older • Routine Osteoporosis Screening: - For women 65 and older - At age 60 for women at increased risk • Adult routine immunizations, such as: - Tetanus, Diphtheria and Pertussis (Tdap) vaccine as a single dose for those 19 years of age and above - Tetanus-Diphtheria (Td) booster every 10 years - Influenza vaccine, annually - Varicella (chicken pox) vaccine for age 19 to 49 years without evidence of immunity to varicella - Pneumococcal vaccine, age 65 and over - Human papillomavirus (HPV) vaccine for age 18 through age 26 - Herpes Zoster (Shingles) vaccine for age 60 and older • The following exams limited to: - 1 routine eye exam every 12 months	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount.

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay
Medical Preventive Care, adult (cont.)	
Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 1-888/238-6240 for information on whether a specific test is considered routine.	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount.
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicetaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	
Not covered: • *Physical exams, immunizations, and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.*	*All charges*
Medical Preventive Care, children	
• We follow the American Academy of Pediatrics (AAP) recommendations for preventive care and immunizations. Go to www.aetnafeds.com for the list of preventive care and immunizations recommended by the American Academy of Pediatrics. • Well-child care charges for routine examinations, immunizations and care (up to age 22) - 7 routine exams from birth to age 12 months - 3 routine exams from age 12 months to 24 months - 3 routine exams from age 24 months to 36 months - 1 routine exam per year thereafter to age 22 • Screening examination of premature infants for Retinopathy of Prematurity-A retinal eye screening exam performed by an ophthalmologist for infants with low birth weight (<1500g) or gestational age of 32 weeks or less and infants weighing between 1500 and 2000g or gestational age of more than 32 weeks with an unstable clinical course. • Hearing loss screening of newborns provided by a participating hospital before discharge • 1 routine eye exam every 12 months through age 17 to determine the need for vision correction • 1 routine hearing exam every 24 months through age 17 to determine the need for hearing correction • Dietary and nutritional counseling for obesity - unlimited visits	In-network: Nothing at a network provider Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount.

Medical Preventive Care, children - continued on next page

Benefit Description	You pay
Medical Preventive Care, children (cont.)	
Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 1-888/238-6240 for information on whether a specific test is considered routine.	In-network: Nothing at a network provider Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount.
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicetaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	
Not covered: • *Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Traditional medical coverage does not begin to pay until you have satisfied your deductible.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network medical preventive care is covered at 100% (see pages 86-89) and is not subject to your calendar year deductible.
- The deductible is: In-network - $600 for Self Only enrollment, $1,200 for Self Plus One, and $1,200 for Self and Family enrollment or Out-of-Network - $1,250 per Self Only, $2,500 per Self Plus One, or $2,500 per Self and Family enrollment. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. You must satisfy your deductible before your Traditional medical coverage may begin. Note: Preventive care, PCP/Specialist office visits and Prescription costs are not subject to the annual in-network deductible.
- Under Traditional medical coverage, in-network benefits apply only when you use a network provider. Out-of-network benefits apply when you do not use a network provider. Your dollars will generally go further when you use network providers because network providers agree to discount their fees.
- Whether you use network or non-network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $5,000 for Self Only enrollment, $6,850 for Self Plus One, or $6,850 for Self and Family enrollment in-network or $5,000 for Self Only enrollment, $10,000 for Self Plus One, or $10,000 for Self and Family enrollment out-of-network in any calendar year, you do not have to pay any more for covered services from network or non-network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Deductible before Traditional medical coverage begins	
You must satisfy your deductible before your Traditional medical coverage begins. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. Once your Traditional medical coverage begins, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions, until you reach the annual catastrophic protection out-of-pocket maximum. At that point, we pay eligible medical expenses for the remainder of the calendar year at 100%.	100% of allowable charges until you meet the deductible: In-network: $600 for Self Only enrollment, $1,200 for Self Plus One enrollment, and $1,200 for Self and Family enrollment Out-of-Network: $1,250 per Self Only enrollment, $2,500 for Self Plus One enrollment, or $2,500 per Self and Family enrollment

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - $600 for Self Only enrollment, $1,200 for Self Plus One enrollment, and $1,200 for Self and Family enrollment or Out-of-Network - $1,250 for Self Only enrollment, $2,500 for Self Plus One enrollment, and $2,500 for Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section. Note: PCP office visits and Specialist office visits are not subject to the annual in-network deductible.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office - Office medical evaluations, examinations and consultations - Second surgical or medical opinion - Initial examination of a newborn child covered under a Self Plus One or Self and Family enrollment • In an urgent care center for a routine service • During a hospital stay • In a skilled nursing facility • At home	In-network: $25 Primary Care Physician (PCP) visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Teladoc consult Please see www.aetnafeds.com for information on Teladoc service. Note: Members will receive a Teladoc welcome kit explaining the benefit Note: Teladoc is not available for service in Missouri, Idaho and Arkansas	In-network: $40 per consult (No deductible) Out-of-network: No benefit. Members must use a Teladoc provider.

Benefit Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CT Scans/MRI* • Ultrasound • Electrocardiogram and electroencephalogram (EEG) *Note: CAT Scans and MRIs require precertification see "Services requiring our prior approval" on pages 24-25.	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Genetic Counseling and Evaluation for BRCA Testing • Genetic Testing for BRCA-Related Cancer* *Note: Requires precertification. See "Services requiring our prior approval" on pages 24-25.	In-network: Nothing at a network provider Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount
Maternity care	
• Complete maternity (obstetrical) care, such as: • Prenatal care - includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	In-network: No coinsurance for prenatal care or the first postpartum care visit, $25 for PCP visit or $40 for specialist visit for postpartum care visits thereafter when services are rendered by an in-network delivering health care provider. (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	
Breastfeeding support, supplies and counseling for each birth	In-network: Nothing at Network Provider Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Home births	*All charges*
Family planning	
A range of voluntary family planning services limited to: • Contraceptive counseling on an annual basis • Voluntary sterilization (See *Surgical procedures* (Section 5b) • Surgically implanted contraceptives • Generic injectable contraceptive drugs, such as Depo-Provera • Intrauterine devices (IUDs) • Diaphragms Note: We cover injectable contraceptives under the medical benefit when supplied by and administered at the provider's office. Injectable contraceptives are covered at the prescription drug benefit when they are dispensed at the Pharmacy. If a member must obtain the drug at the pharmacy and bring it to the provider's office to be administered, the member would be responsible for both the Rx and office visit cost shares. We cover oral contraceptives under the prescription drug benefit.	In-network: Nothing for women For men: (No deductible) $25 per PCP visit $40 for Specialist visit Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling.*	*All charges*
Infertility services	
Infertility is a disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (6 months for women age 35 or older). • Testing for diagnosis and surgical treatment of the underlying cause of infertility.	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Any assisted reproductive technology (ART) procedure or services related to such procedures, including but not limited to in-vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection or* • *Artificial insemination and monitoring of ovulation:* *• Intravaginal insemination (IVI)* *• Intracervical insemination (ICI)* *• Intrauterine insemination (IUI) or* • *Any charges associated with care required to obtain ART services (e.g. office, hospital, ultrasounds, laboratory tests, etc); and any charges associated with obtaining sperm for any ART procedures.*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	
• *Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services* • *Services associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g. office, hospital, ultrasounds, laboratory tests etc.)* • *Services and supplies related to the above mentioned services, including sperm processing* • *The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;* • *Reversal of sterilization surgery.* • *Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal* • *Injectable fertility drugs, including but not limited to menotropins, hCG, GnRH agonists, and IVIG* • *Infertility treatment when the FSH level is 19 mIU/ml or greater on day 3 of menstrual cycle* • *Cost of home ovulation predictor kits or home pregnancy kits* • *Drugs related to the treatment of non-covered benefits* • *Infertility services that are not reasonably likely to result in success*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections • Allergy serum	In-network: $25 PCP visit, $40 per specialist visit, nothing for serum (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 104. • Respiratory and inhalation therapy • Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy — Home IV and antibiotic therapy must be precertified by your attending physician. • Growth hormone therapy (GHT) Note: We cover growth hormone injectables under the prescription drug benefit.	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	
Note: We will only cover GHT when we preauthorize the treatment. Call 1-888/238-6240 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and it is authorized by Aetna. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Applied Behavioral Analysis (ABA)	*All charges*
Physical and occupational therapies	
60 visits per person, per calendar year for physical or occupational therapy, or a combination of both for the services of each of the following: • Qualified Physical therapists • Occupational therapists Note: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient therapy is covered under Hospital/Extended Care Benefits. • Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome Note: Physical therapy treatment of lymphedemas following breast reconstruction surgery is covered under the Reconstructive surgery benefit - see section 5(b).	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Long-term rehabilitative therapy*	*All charges*
Pulmonary and cardiac rehabilitation	
• 20 visits per condition per member per calendar year for pulmonary rehabilitation to treat functional pulmonary disability. • Cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or a myocardial infarction is provided for up to 3 visits a week for a total of 18 visits.	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Long-term rehabilitative therapy	*All charges*
Habilitative Services	
Habilitative services for children under age 19 with congenital or genetic birth defects including, but not limited to, autism or an autism spectrum disorder, and cerebral palsy. Treatment is provided to enhance the child's ability to function. Services include occupational therapy, physical therapy and speech therapy. Note: See Occupational therapy, physical therapy and speech therapy for plan coverage and limitations.	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible…
Speech therapy	
• 60 visits per person, per calendar year.	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Hearing services (testing, treatment, and supplies)	
• Hearing exams for children through age 17 (*as shown in Preventive Care, children*) • One hearing exam every 24 months for adults • Audiological testing and medically necessary treatments for hearing problems. Note: Discounts on hearing exams, hearing services, and hearing aids are also available. Please see the Non-FEHB Benefits section of this brochure for more information.	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *All other hearing testing and services that are not shown as covered* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Treatment of eye diseases and injury	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
One routine eye exam (including refraction) every 12-month period (See In-Network Medical Preventive Care)	In-network: Nothing Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Fitting of contact lenses* • *Vision therapy, including eye patches and eye exercises, e.g., orthoptics, pleoptics, for the treatment of conditions related to learning disabilities or developmental delays* • *Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Foot care	
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: $25 PCP visit, $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open manipulation or fixation)* • *Foot orthotics* • *Podiatric shoe inserts*	*All charges*
Orthopedic and prosthetic devices	
• Orthopedic devices such as braces and corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and prosthetic devices such as artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), and surgically implanted breast implant following mastectomy, and lenses following cataract removal. See Section 5(b) for coverage of the surgery to insert the device. • Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.)	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Hair prosthesis prescribed by a physician for hair loss resulting from radiation therapy, chemotherapy or certain other injuries, diseases, or treatment of a disease. Note: Plan lifetime maximum of $500.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Orthopedic and corrective shoes not attached to a covered brace* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Podiatric shoe inserts* • *Lumbosacral supports* • *Penile implants* • *All charges over $500 for hair prosthesis*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Contact Plan at 1-888/238-6240 for specific covered DME. Some covered items include: • Oxygen • Dialysis equipment • Hospital beds (Clinitron and electric beds must be preauthorized) • Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Insulin pumps and related supplies such as needles and catheters • Certain bathroom equipment such as bathtub seats, benches and lifts Note: Some DME may require precertification by you or your physician.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Home modifications such as stair glides, elevators and wheelchair ramps* • *Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities*	*All charges*
Home health services	
• Home health services ordered by your attending physician and provided by nurses and home health aides through a home health care agency. Home health services include skilled nursing services provided by a licensed nursing professional; services provided by a physical therapist, occupational therapist, or speech therapist; and services of a home health aide when provided in support of the skilled home health services. Home health services are limited to 3 visits per day with each visit equal to a period of 4 hours or less. Your attending physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications. Note: Skilled nursing under Home health services must be precertified by your attending Physician.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Nursing care for the convenience of the patient or the patient's family* • *Transportation* • *Custodial care, i.e., home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative and appropriate for the active treatment of a condition, illness, disease, or injury* • *Services of a social worker* • *Services provided by a family member or resident in the member's home* • *Services rendered at any site other than the member's home*	*All charges*

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Home health services (cont.)	
• *Services rendered when the member is not homebound because of illness or injury* • *Private duty nursing services*	*All charges*
Chiropractic	
See Alternative Medicine Treatments	*All charges above benefits shown in Alternative Medicine Treatments.*
Alternative medicine treatments	
Chiropractic and Acupuncture - 20 visits per person per calendar year for chiropractic or acupuncture or a combination of both Acupuncture - when provided as anesthesia for covered surgery Note: See page 110 for our coverage of acupuncture when provided as anesthesia for covered surgery. See Section 5 Non-FEHB benefits available to Plan members for discount arrangements.	In-network: 20% of our Plan allowance (No deductible) Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Other alternative medical treatments including but not limited to: • *Acupuncture other than stated above* • *Applied kinesiology* • *Aromatherapy* • *Biofeedback* • *Craniosacral therapy* • *Hair analysis* • *Reflexology*	*All charges*
Educational classes and programs	
Aetna Health Connections offers disease management for 34 conditions. Included are programs for: • Asthma • Cerebrovascular disease • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Coronary artery disease • Cystic Fibrosis • Depression • Diabetes • Hepatitis • Inflammatory bowel disease • Kidney failure • Low back pain • Sickle cell disease	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible…
Educational classes and programs (cont.)	
To request more information on our disease management programs, call 1-888-238-6240.	Nothing
Coverage is provided for: • Tobacco Cessation Programs, including individual group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Note: OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	In-network: Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence. Out-of-network: Nothing up to our Plan allowance for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing up to our Plan allowance for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence.
Not covered: *Applied Behavioral Analysis (ABA)*	*All charges*

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - $600 for Self Only enrollment, $1,200 for Self Plus One enrollment, and $1,200 for Self and Family enrollment or Out-of-Network - $1,250 for Self Only enrollment, $2,500 for Self Plus One enrollment, and $2,500 for Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual has a body mass index (BMI) exceeding 40 or a BMI greater than 35 in conjunction with documented significant co-morbid conditions (such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea or refractory hypertension). - Eligible members must be age 18 or over or have completed full growth.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
- Members must complete a physician-supervised nutrition and exercise program within the past two years for a cumulative total of six months or longer in duration, with participation in one program for at least three consecutive months, prior to the date of surgery documented in the medical record by an attending physician who supervised the member's participation; or member participation in an organized multidisciplinary surgical preparatory regimen of at least three months duration proximate to the time of surgery. - For members who have a history of severe psychiatric disturbance or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary. **We will consider:** • Open or laparoscopic Roux-en-Y gastric bypass; or • Open or laparoscopic biliopancreatic diversion with or without duodenal switch; or • Sleeve gastrectomy; or • Laparoscopic adjustable silicone gastric banding (Lap-Band) procedures. • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization for men (e.g., vasectomy) • Treatment of burns • Skin grafting and tissue implants • Gender reassignment surgery* - The Plan will provide coverage for the following when the member meets Plan criteria: • Surgical removal of breasts for female-to-male patients • Surgical removal of uterus and ovaries in female-to-male and testes in male-to-female • Reconstruction of external genitalia** * Subject to medical necessity ** Note: Requires Precertification. See "Services requiring our prior approval" on pages 24-25. You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 1-888/238-6240.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Voluntary sterilization for women (e.g., tubal ligation)	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
Not covered: • *Reversal of voluntary surgically-induced sterilization* • *Surgery primarily for cosmetic purposes* • *Radial keratotomy and laser surgery, including related procedures designed to surgically correct refractive errors* • *Routine treatment of conditions of the foot; see Foot care* • *Gender reassignment services that are not considered medically necessary*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital and developmental anomalies are cleft lip, cleft palate, webbed fingers, and webbed toes. All surgical requests must be preauthorized. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedema - breast prostheses and surgical bras and replacements (*see Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form and for which the disfigurement is not associated with functional impairment, except repair of accidental injury*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery	
Oral surgical procedures, that are medical in nature, such as: • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ (must be preauthorized); and • Excision of tumors and cysts. Note: When requesting oral and maxillofacial services, please check DocFind or call Member Services at 1-888-238-6240 for a participating oral and maxillofacial surgeon.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Dental implants* • *Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on pages 24-25. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas; Pancreas/Kidney (simultaneous)	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)* - Hemoglobinopathies - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for:	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Ependymoblastoma - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors *Approved clinical trial necessary for coverage.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (ie.e, myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	In network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs)	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell anemia • Autologous Transplants for: - Advanced Childhood kidney cancers - Advance Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Breast cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• **National Transplant Program (NTP) -** Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your primary care doctor and plan specialist physician and approved by our medical director in advance of the surgery. To receive in-network benefits the transplant must be performed at hospitals (Institutes of Excellence) specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.	

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four allogenic bone marrow/stem cell transplant donors in addition to the testing of family members.	
Clinical trials must meet the following criteria: A. The member has a current diagnosis that will most likely cause death within one year or less despite therapy with currently accepted treatment; or the member has a diagnosis of cancer; AND B. *All* of the following criteria must be met: 1. Standard therapies have not been effective in treating the member or would not be medically appropriate; and 2. The risks and benefits of the experimental or investigational technology are reasonable compared to those associated with the member's medical condition and standard therapy based on at least two documents of medical and scientific evidence (as defined below); and 3. The experimental or investigational technology shows promise of being effective as demonstrated by the member's participation in a clinical trial satisfying ALL of the following criteria: a. The experimental or investigational drug, device, procedure, or treatment is under current review by the FDA and has an Investigational New Drug (IND) number; and b. The clinical trial has passed review by a panel of independent medical professionals (evidenced by Aetna's review of the written clinical trial protocols from the requesting institution) approved by Aetna who treat the type of disease involved and has also been approved by an Institutional Review Board (IRB) that will oversee the investigation; and c. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national cooperative body (e.g., Department of Defense, VA Affairs) and conforms to the rigorous independent oversight criteria as defined by the NCI for the performance of clinical trials; and d. The clinical trial is not a single institution or investigator study (NCI designated Cancer Centers are exempt from this requirement); and 4. The member must: a. Not be treated "off protocol," and b. Must actually be enrolled in the trial.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Not covered: • *The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials. Terminal illness means a medical prognosis of 6 months or less to live); and* • *Costs of data collection and record keeping that would not be required but for the clinical trial; and* • *Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs"); and* • *Items and services provided by the trial sponsor without charge* • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services (including Acupuncture - when provided as anesthesia for a covered surgery) provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - $600 for Self Only enrollment, $1,200 for Self Plus One enrollment, and $1,200 for Self and Family enrollment or Out-of-Network - $1,250 for Self Only enrollment, $2,500 for Self Plus One enrollment, and $2,500 for Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR NON-NETWORK FACILITY CARE**. Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as • Private, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, Immunoglobulin, and prolastin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
• Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Whole blood and concentrated red blood cells not replaced by the member* • *Non-covered facilities, such as nursing homes, schools* • *Custodial care, rest cures, domiciliary or convalescent cares* • *Personal comfort items, such as a telephone, television, barber service, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Radiologic procedures, diagnostic laboratory tests, and X-rays when associated with a medical procedure being done the same day • Pathology Services • Administration of blood, blood plasma, and other biologicals • Blood products, derivatives and components, artificial blood products and biological serum • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), penile implants, defibrillator, surgically implanted breast implant following mastectomy, and lenses following cataract removal. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Note: In-network preventive care services are not subject to coinsurance listed.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Whole blood and concentrated red blood cells not replaced by the member.	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 60-day limit per calendar year when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Custodial care	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of your attending Physician, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less. Note: Inpatient hospice services require prior approval.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Ambulance	
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency* • *Ambulette service* • *Ambulance transportation for member convenience or reasons that are not medically necessary* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - $600 for Self Only enrollment, $1,200 for Self Plus One enrollment, and $1,200 for Self and Family enrollment or Out-of-Network - $1,250 for Self Only enrollment, $2,500 for Self Plus One enrollment, and $2,500 for Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child. If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify Aetna as soon as possible.

Benefit Description	You pay After the calendar year deductible…
Emergency	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services	In-network: 20% of our Plan allowance Out-of-network: 20% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Elective or non-emergency care	*All charges*

Benefit Description	You pay After the calendar year deductible…
Ambulance	
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member. Note: Air ambulance may be covered. Prior approval is required.	In-network: 20% of our Plan allowance Out-of-network: 20% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency* • *Ambulette service* • *Air ambulance without prior approval* • *Ambulance transportation for member convenience or for reasons that are not medically necessary* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for certain services.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- The deductible is: In-network - $600 for Self Only enrollment, $1,200 for Self Plus One enrollment, and $1,200 for Self and Family enrollment or Out-of-Network - $1,250 for Self Only enrollment, $2,500 for Self Plus One enrollment, and $2,500 for Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section. Note: PCP office visits and Specialist office visits are not subject to the annual in-network deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. Preauthorization is required for the following:
  - Any intensive outpatient care (minimum of two (2) hours per day or six (6) hours per week - can include group, individual, family or multi-family group psychotherapy, etc.)
  - Outpatient detoxification
  - Partial hospitalization
  - Any inpatient or residential care
  - Psychological or neuropsychological testing
  - Outpatient electroconvulsive therapy
  - Biofeedback and amytal interview
  - Psychiatric home health care
- Aetna can assist you in locating participating providers in the Plan, unless your needs for covered services extend beyond the capability of the affiliated providers. Emergency care is covered (See Section 5(d), Emergency services/accidents). You can receive information regarding the appropriate way to access the behavioral health care services that are covered under your specific plan by calling member Services at 1-888/238-6240. A referral from your PCP is not necessary to access behavioral health care but your PCP may assist in coordinating your care.
- We will provide medical review criteria for denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-network: $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	In-network: $40 per specialist visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility including an overnight residential treatment facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility including an overnight residential treatment facility • Services in approved treatment programs, such as partial hospitalization, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	In-network: $40 per Outpatient visit (No deductible) Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible…
Not covered	
• *Educational services for treatment of behavioral disorders* • *Services in half-way houses* • *Applied Behavioral Analysis (ABA)*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- This is a five tier open formulary pharmacy plan. A formulary is a list of generic and brand-name drugs that your health plan covers. Each drug is associated with a tier on the formulary list. Tier-one is generic drugs on our formulary list, Tier-two is brand name drugs on our formulary list, Tier-three is drugs not on our formulary list, Tier-four is preferred specialty drugs and Tier-five is non-preferred specialty drugs. Each tier has a separate out-of-pocket cost.
- We cover prescribed drugs and medications, as described in the chart beginning on the third page. Copayment/coinsurance levels reflect in-network pharmacies only. If you obtain your prescription at an out-of-network pharmacy (non-preferred), you will be reimbursed at our Plan allowance less 50%. You are responsible for any difference between our Plan allowance and the billed amount.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- For prescription drugs and medications, In-network: Deductible does not apply. Out-of-Network: You must first satisfy your deductible. Out-of-Network: $1,250 for Self Only enrollment, $2,500 for Self Plus One enrollment, and $2,500 for Self and Family enrollment each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The out-of-network deductible applies to all out-of-network benefits in this Section. The cost of your prescription is based on the Aetna contracted rate with network pharmacies. The Aetna contracted rate with the network pharmacy does not reflect or include any rebates Aetna receives from drug manufacturers.
- In-network, you will pay a copayment or coinsurance at in-network retail pharmacies or the mail-order pharmacy for prescriptions under your Traditional medical coverage. Out-of-network, once you satisfy the deductible you will pay 50% coinsurance plus the difference between our Plan allowance and the billed amount at out-of-network retail pharmacies. There is no out-of-network mail order pharmacy program.
- Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Upon approval by the Plan, the prescription is covered for the current calendar year or a specified time period, whichever is less.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of which include:

- **Who can write your prescription.** A licensed physician or dentist or, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.

- **Where you can obtain them.** Any retail pharmacy can be used for up to a 30-day supply. Our mail order program must be utilized for a 31-day up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay (retail pharmacy), and for a 31-day up to a 90-day supply of medication for two copays (mail order). For retail pharmacy transactions, you must present your Aetna Member ID card at the point of sale for coverage. Please call Member Services at 1-888-238-6240 for more details on how to use the mail order program. **Mail order is not available for drugs and medications ordered through Aetna Specialty Pharmacy. Prescriptions ordered through Aetna Specialty Pharmacy are only filled for up to a 30-day supply due to the nature of these prescriptions.** If accessing a nonparticipating pharmacy, the member must pay the full cost of the medication at the point of service, then submit a complete paper claim and a receipt for the cost of the prescription to our Direct Member Reimbursement (DMR) unit. Reimbursements are subject to review to determine if the claim meets applicable requirements, and are subject to the terms and conditions of the benefit plan and applicable law.
- **We use a formulary.** Drugs are prescribed by attending licensed doctors and covered in accordance with the Plan's drug formulary; however, coverage is not limited to medications included on the formulary. Many non-formulary drugs are also covered but a higher copayment will apply. Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Visit our website at www.aetnafeds.com to review our Formulary Guide or call 1-888-238-6240.
- **Drugs not on the formulary.** Aetna has a Pharmacy and Therapeutics Committee, comprised of physicians, pharmacists and other clinicians that review drugs for inclusion in the formulary. They consider the drug's effectiveness, safety and cost in their evaluation. While most of the drugs on the non-formulary list are brand drugs, some generic drugs also may be on the non-formulary list. For example, this may happen when brand medications lose their patent and the FDA has granted a period of exclusivity to specific generic manufacturers. When this occurs, the price of the generic drug may not decrease as you might think most generic drugs do. This period of exclusivity usually ranges between 3-6 months. Once this time period expires, competition from other generic manufacturers will generally occur and this helps lower the price of the drug and this may lead Aetna to re-evaluate the generic for possible inclusion on the formulary. Aetna will place some of these generic drugs that are granted a period of exclusivity on our non-formulary list, which requires the highest copay level.
- **Choose generics.** The Plan requires the use of generics if a generic drug is available. If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained from the Plan. Generics contain the same active ingredients in the same amounts as their brand name counterparts and have been approved by the FDA. By using generic drugs, you will see cost savings, without jeopardizing clinical outcome or compromising quality.
- **Precertification.** Your pharmacy benefits plan includes our precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by our Pharmacy Management Precertification Unit before they will be covered. Only your physician or pharmacist, in the case of an antibiotic or analgesic, can request prior authorization for a drug. Step-therapy is another type of precertification under which certain medications will be excluded from coverage unless you try one or more "prerequisite" drug(s) first, or unless a medical exception is obtained. The drugs requiring precertification or step-therapy are subject to change. Visit our website at www.aetnafeds.com for the most current information regarding the precertification and step-therapy lists. Ask your physician if the drugs being prescribed for you require precertification or step therapy.
- **When to use a participating retail or mail order pharmacy.** Covered prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy may be dispensed for up to a 30-day supply. Members must obtain a 31-day up to a 90-day supply of covered prescription medication through mail order. In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available. (See choose generics above) Drug costs are calculated based on Aetna's contracted rate with the network pharmacy excluding any drug rebates. While Aetna Rx Home Delivery is most likely the most cost effective option for most prescriptions, there may be some instances where the most cost effective option for members will be to utilize a retail pharmacy for a 30-day supply versus Aetna Rx Home Delivery. Members should utilize the Cost of Care Tool on Aetna Navigator prior to ordering prescriptions through mail order (Aetna Rx Home Delivery) to determine the cost.

In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filing of their medication(s) prior to departure, their pharmacist will need to contact Aetna. Coverage of additional prescriptions will only be allowed if there are refills remaining on the member's current prescription or a new prescription has been issued by their physician. The member is responsible for the applicable copayment for the additional prescription.

- Aetna allows coverage of a medication filling when at least 80% of the previous prescription according to the physician's prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a new prescription to be covered on the 23rd day, thereby allowing a member to have an additional supply of their medication, in case of emergency.
- **When you do have to file a claim.** Send your itemized bill(s) to: Aetna, Pharmacy Management, P.O. Box 52444, Phoenix, AZ 85072-2444.

Here are some things to keep in mind about our prescription drug program:

- **Specialty drugs.** Specialty drugs are medications that treat complex, chronic diseases. Our specialty drug program is called Aetna Specialty CareRx, which includes select oral, injectable and infused medications. Because of the complex therapy needed, a pharmacist or nurse should check in with you often during your treatment. The first fill of these medications can be obtained through a participating retail pharmacy or specialty pharmacy. However, you must obtain all subsequent refills through a participating specialty pharmacy such as Aetna Specialty Pharmacy.

  Certain Aetna Specialty CareRx medications identified with a (+) next to the drug name may be covered under the medical or pharmacy section of this brochure depending on how and where the medication is administered.

  Often these drugs require special handling, storage and shipping. In addition, these medications are not always available at retail pharmacies. For a detailed listing of what medications fall under your Aetna Specialty CareRx benefit please visit: www.AetnaSpecialtyCareRx.com. You can also visit www.aetnafeds.com for the 2016 Aetna Specialty CareRx list or contact us at 1-888/238-6240 for a copy. Note that the medications and categories covered are subject to change.
- To request a printed copy of the Aetna Preferred Drug (Formulary) Guide, call 1-888/238-6240. The information in the Aetna Preferred Drug (Formulary) Guide is subject to change. As brand name drugs lose their patents and the exclusivity period expires, and new generics become available on the market, the brand name drug may be removed from the formulary. Under your benefit plan, this will result in a savings to you, as you pay a lower prescription copayment for generic formulary drugs. Please visit our website at www.aetnafeds.com for current Aetna Preferred Drug (Formulary) Guide information.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by your licensed attending physician or dentist and obtained from a Plan pharmacy or through our mail order program or an out-of-network retail pharmacy: • Drugs and medicines approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as *Not covered* • Self-injectable drugs • Diabetic supplies limited to lancets, alcohol swabs, urine test strips/ tablets, and blood glucose test strips • Insulin • Disposable needles and syringes for the administration of covered medications	**In-network: Deductible does not apply.** Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered generic formulary drug; 30% per covered brand name formulary drug up to a $600 maximum; and 50% per covered non-formulary (generic or brand name) drug up to a $600 maximum. Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 per covered generic formulary drug

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	**In-network: Deductible does not apply.** Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered generic formulary drug; 30% per covered brand name formulary drug up to a $600 maximum; and 50% per covered non-formulary (generic or brand name) drug up to a $600 maximum. Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 per covered generic formulary drug 30% per covered brand name formulary drug up to a $1,200 maximum; and 50% per covered non-formulary (generic or brand name) drug up to a $1,200 maximum. **Out-of-network (retail pharmacies only):** The full cost of the prescription is applied to the deductible before any benefits are considered for payment under the pharmacy plan. Once the deductible is satisfied, the following will apply: 50% plus the difference between our Plan allowance and the billed amount.
We cover the following medications based on the US Preventive Services Task Force A and B recommendations. A prescription is required and must be processed through our pharmacy claim system. • Aspirin for adults age 45 and older (325 mg in strength or less) • Iron supplementation for children ages 6 to 12 months • Oral fluoride for children ages 6 months through age 5 • Vitamin D for adults age 65 and older • Folic acid supplementation for females	**In-network:** Nothing
Women's contraceptive drugs and devices • Generic oral contraceptives on our formulary list • Generic injectable contraceptives on our formulary list - 5 vials per calendar year • Generic emergency contraception, including OTC when filled with a prescription • Diaphragms - 1 per calendar year	**In-network:** Nothing **Out-of-network (retail pharmacies only):** 50% plus the difference between our Plan allowance and the billed amount.

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
• Brand name contraceptive drugs • Brand name injectable contraceptive drugs such as Depo Provera - 5 vials per calendar year • Brand emergency contraception Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	Retail Pharmacy, for up to a 30-day supply per prescription or refill: 30% per covered brand name formulary drug up to a $600 maximum; and 50% per covered non-formulary (generic or brand name) drug up to a $600 maximum. Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: 30% per covered brand name formulary drug up to a $1,200 maximum; and 50% per covered non-formulary (generic or brand name) drug up to a $1,200 maximum. **Out-of-network (retail pharmacies only):** 50% plus the difference between our Plan allowance and the billed amount.
Specialty Medications **Specialty medications must be filled through a specialty pharmacy such as Aetna Specialty Pharmacy**. These medications are not available through the mail order benefit. Certain Aetna Specialty CareRx medications identified with a (+) next to the drug name may be covered under the medical or pharmacy section of this brochure. Please refer to page 121, Specialty Drugs for more information or visit: www.AetnaSpecialtyCareRx.com.	Up to a 30-day supply per prescription or refill: Preferred: 50% up to a $600 maximum Non-preferred: 50% up to $1,200 maximum
Limited benefits: • Drugs to treat erectile dysfunction are limited up to 4 tablets per 30-day period. • Imitrex (limited to 48 kits per calendar year) Note: Mail order is not available.	**In-network:** Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered generic formulary drug; 30% up to $600 per covered brand name formulary drug; and 50% up to $600 per covered non-formulary (generic or brand name) drug. **Out-of-network** (retail pharmacies only)**:** 50% plus the difference between our Plan allowance and the billed amount.
Not covered: • *Drugs used for the purpose of weight reduction, such as appetite suppressants* • *Drugs for cosmetic purposes, such as Rogaine* • *Drugs to enhance athletic performance*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
• *Medical supplies such as dressings and antiseptics* • *Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug) unless required by law* • *Lost, stolen or damaged drugs* • *Vitamins (including prescription vitamins), nutritional supplements, and any food item, including infant formula, medical foods and other nutritional items, even if it is the sole source of nutrition unless otherwise stated.* • *Prophylactic drugs including, but not limited to, anti-malarials for travel* • *Fertility drugs* • *Compounded bioidentical hormone replacement (BHR) therapy that includes progesterone, testosterone and/or estrogen.* • *Compounded thyroid hormone therapy* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit. (See page 100). OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 coordinating benefits with other coverage.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5(c) for inpatient hospital benefits.

Dental benefits	You Pay After the calendar year deductible...
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Dental benefits	
We have no other dental benefits.	

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Aetna Navigator®	Aetna Navigator, our secure member self-service website, provides you with the tools and personalized information to help you manage your health. Click on Aetna Navigator from www.aetnafeds.com to register and access a secure, personalized view of your Aetna benefits. With Aetna Navigator, you can: • Print temporary ID cards • Download details about a claim such as the amount paid and the member's responsibility • Contact member services at your convenience through secure messages • Access cost and quality information through Aetna's transparency tools • View and update your Personal Health Record • Find information about the perks that come with your Plan • Access health information through Healthwise® Knowledgebase Registration assistance is available toll free, Monday through Friday, from 7am to 9pm Eastern Time at 1-800/225-3375. Register today at www.aetnafeds.com.
Informed Health® Line	Provides eligible members with telephone access to registered nurses experienced in providing information on a variety of health topics. Informed Health Line is available 24 hours a day, 7 days a week. You may call Informed Health Line at 1-800/556-1555. We provide TDD service for the hearing and speech-impaired. We also offer foreign language translation for non-English speaking members. Informed Health Line nurses cannot diagnose, prescribe medication or give medical advice.

Services for the deaf and hearing-impaired	1-800/628-3323

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information, contact the plan at 1-888/238-6240 or visit their website at www.aetnafeds.com.

Aetna Vision^{SM} Discounts

You are eligible to receive substantial discounts on eyeglasses, contact lenses, Lasik — the laser vision corrective procedure, and nonprescription items including sunglasses and eyewear products through the Aetna Vision Discounts with more than 22,600 provider locations across the country.

This eyewear discount enriches the routine vision care coverage provided in your health plan, which includes an eye exam from a participating provider.

For more information on this program call toll free 1-800/793-8616. For a referral to a Lasik provider, call 1-800/422-6600.

Aetna Hearing ^{SM} Discount Program

The Hearing discount program helps you and your family (including parents and grandparents) save on hearing exams, hearing services and hearing aids. This program is offered in conjunction with Amplifon Hearing Health Care and includes access to over 1,600 participating locations. Amplifon Hearing Health Care provides discounts on hearing exams, hearing services, hearing aid repairs, and choice of the latest technologies. Call Amplifon Hearing Health Care customer service at 1-888/432-7464. Make sure the Amplifon Hearing Health Care customer service representative knows you are an Aetna member. Amplifon Hearing Health Care will send you a validation packet and you will receive the discounts at the point of purchase.

Aetna Fitness ^{SM} Discount Program

Access preferred rates* on memberships at thousands of gyms nationwide through the GlobalFit® network, plus discounts on at-home weight-loss programs, home fitness options, and one-on-one health coaching services.

Visit www.globalfit.com/fitness to find a gym or call 1-800/298-7800 to sign up.

*Membership to a gym of which you are now, or were recently a member, may not be available.

Aetna Natural Products and Services ^{SM} Discount Program

Offers reduced rates on acupuncture, chiropractic care, massage therapy, and dietetic counseling as well as discounts on over-the-counter vitamins, herbal and nutritional supplements, and yoga equipment. Through Vital Health Network, you can receive a discount on online consultations and information, please call Aetna Member Services at 1-888/238-6240.

Aetna Weight Management ^{SM} Discount Program

The Aetna Weight Management Discount Program provides you and your eligible family members with access to discounts on eDiets® diet plans and products, Jenny® weight loss programs, Calorie King® memberships and products and Nutrisystem® weight loss meal plans. You can choose from a variety of programs and plans to meet your specific weight loss goals and save money. For more information, please call Aetna Member Services at 1-888/238-6240.

Health Insurance Plan for Individuals

Your family members who are not eligible for FEHB coverage may be eligible for a health insurance plan for individuals with Aetna. For more information on all our health insurance for individuals visit AetnaInsurance.com.

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this Section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services*.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Procedures, services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Cost of data collection and record keeping for clinical trials that would not be required, but for the clinical trial.
- Items and services provided by clinical trial sponsor without charge.
- Care for conditions that state or local law requires to be treated in a public facility, including but not limited to, mental illness commitments.
- Court ordered services, or those required by court order as a condition of parole or probation, except when medically necessary.
- Educational services for treatment of behavioral disorders.
- Applied Behavioral Analysis (ABA)

Section 7. Filing a claim for covered services

This section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical, hospital and prescription drug benefits

To obtain claim forms or other claims filing advice or answers about your benefits, contact us at 1-888/238-6240.

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 1-888/238-6240, or at our website at www.aetnafeds.com.

When you must file a claim, such as when you use non-network providers, for services you receive overseas or when another group health plan is primary, submit it on the Aetna claim form. You can obtain this form by either calling us at 1-888/238-6240 or by logging onto your personalized home page on Aetna Navigator from the www.aetnafeds.com website and clicking on "Forms." Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee
- Covered member's name, date of birth, address, phone number and ID number
- Name, address and taxpayer identification number of person or firm providing the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) payments or denial from any primary payor - such as Medicare Summary Notice (MSN) with your claim
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed
- Claims for prescription drugs and supplies that are not obtained from a network pharmacy or through the Mail Order Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date and charge
- You should provide an English translation and currency conversion rate at the time of services for claims for overseas (foreign) services

Records

Keep a separate record of the medical expenses of each covered family member. Save copies of all medical bills, including those you accumulate to satisfy your deductible. In most instances, they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible:

Aetna Life Insurance Company
P.O. Box 14079
Lexington, KY 40512-4079

You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

For covered services you receive in hospitals outside the United States and performed by physicians outside the United States, send a completed Claim Form and the itemized bills to the following address. Also send any written inquiries, concerning the processing of overseas claims to:

Aetna Life Insurance Company
P.O. Box 14079
Lexington, KY 40512-4079

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.aetnafeds.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Aetna, Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512 or calling 1-888/238-6240.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Disagreements between you and the CDHP fiduciary regarding the administration of an HRA are not subject to the disputed claims process.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Aetna Inc., Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address, if you would like to receive our decision via email. Please note that by providing us your email address, you may receive our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us--if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond our control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

	OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-888/238-6240. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the national Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

When we are the primary payor, we pay the benefits described in this brochure.

When we are the secondary payor, the primary Plan will pay for the expenses first, up to its plan limit. If the expense is covered in full by the primary plan, we will not pay anything. If the expense is not covered in full by the primary plan, we determine our allowance. If the primary Plan uses a preferred provider arrangement, we use the highest negotiated fee between the primary Plan and our Plan. If the primary plan does not use a preferred provider arrangement, we use the Aetna negotiated fee. For example, we generally only make up the difference between the primary payor's benefit payment and 100% of our Plan allowance, subject to your applicable deductible, if any, and coinsurance or copayment amounts.

When Medicare is the primary payor and the provider accepts Medicare assignment, our allowance is the difference between Medicare's allowance and the amount paid by Medicare. We do not pay more than our allowance. You are still responsible for your copayment, deductible or coinsurance based on the amount left after Medicare payment.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or Illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

For a complete explanation on how the Plan is authorized to operate when others are responsible for your injuries please go to: www.aetnafeds.com.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. If you are enrolled in our CDHP option and a FEDVIP Dental Plan, the FEDVIP plan will pay first for dental services and your Dental Fund will pay second, except for diagnostic and preventive care. When you use an in network provider, diagnostic and preventive care will be reimbursed at 100% and not count against your Dental Fund, see page 45. When you use a non-network dentist for these services, the Dental Fund will pay first and your FEDVIP plan will pay second. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Recovery rights related to Workers' Compensation

If benefits are provided by Aetna for illness or injuries to a member and we determine the member received Workers' Compensation benefits through the Office of Workers' Compensation Programs (OWCP), a workers' compensation insurance carrier or employer, for the same incident that resulted in the illness or injuries, we have the right to recover those benefits as further described below. "Workers' Compensation benefits" includes benefits paid in connection with a Workers' Compensation claim, whether paid by an employer directly, the OWCP or any other workers' compensation insurance carrier, or any fund designed to provide compensation for workers' compensation claims. Aetna may exercise its recovery rights against the member if the member has received any payment to compensate them in connection with their claim. The recovery rights against the member will be applied even though:

a) The Workers' Compensation benefits are in dispute or are paid by means of settlement or compromise;

b) No final determination is made that bodily injury or sickness was sustained in the course of or resulted from the member's employment;

c) The amount of Workers' Compensation benefits due to medical or health care is not agreed upon or defined by the member or the OWCP or other Workers' Compensation carrier; or

d) The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

By accepting benefits under this Plan, the member or the member's representatives agree to notify Aetna of any Workers' Compensation claim made, and to reimburse us as described above.

Aetna may exercise its recovery rights against the provider in the event:

a) the employer or carrier is found liable or responsible according to a final adjudication of the claim by the OWCP or other party responsible for adjudicating such claims; or

b) an order approving a settlement agreement is entered; or

c) the provider has previously been paid by the carrier directly, resulting in a duplicate payment.

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan. See pages 65 and 107.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs. See pages 67 and 110.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs. See pages 67 and 110.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age

- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY:1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure.

For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800/772-1213 (TTY: 1-800/325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (SSA TTY: 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized or precertified as required. Also, please note that if your attending physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-888-238-6240.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table. It illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

CDHP: In-network example

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$1,000 Self Only/$2,000 Self Plus One or Self and Family	$1,000 Self Only/$2,000 Self Plus One or Self and Family
Out-of-Pocket Maximum	$4,000 Self Only/$6,850 Self Plus One or Self and Family	$4,000 Self Only/$6,850 Self Plus One or Self and Family
Primary Care Physician	15% of plan allowance	15% of plan allowance
Specialist	15% of plan allowance	15% of plan allowance
Inpatient Hospital	15% of plan allowance	15% of plan allowance
Outpatient Hospital	15% of plan allowance	15% of plan allowance
Rx (30-day supply)	Tier 1 - $10 Tier 2 - $35 Tier 3 - $75 Tier 4 – Preferred Specialty 50% up to $250 maximum Tier 5 - Non-preferred specialty 50% up to $500 maximum	Tier 1 - $10 Tier 2 - $35 Tier 3 - $75 Tier 4 – Preferred Specialty 50% up to $250 maximum Tier 5 - Non-preferred Specialty 50% up to $500 maximum
Rx – Mail Order (31-90 day supply)	2x retail copay	2x retail copay

You can find more information about how our plan coordinates benefits with Medicare by calling 1-888/238-6240 or visit our website at www.aetnafeds.com.

- **Tell us about your Medicare coverage**

  You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country.

  To learn more about Medicare Advantage plans, contact Medicare at 1-800/MEDICARE (1-800-633-4227), (TTY:1-877-486-2048) or at www.medicare.gov.

  If you enroll in a Medicare Advantage plan, the following options are available to you:

  This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage Plan and also remain enrolled in our FEHB Plan. If you are an annuitant or former spouse with FEHBP coverage and are enrolled in Medicare Parts A and B, you may enroll in our Medicare Advantage plan if one is available in your area. **We do not waive cost-sharing for your FEHB coverage.** For more information, please call us at 1-888/788-0390.

  This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductible. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

  Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. For more information, please call us at 1-800/832-2640. **See Important Notice from Aetna about our Prescription Drug Coverage and Medicare** on the first inside page of this brochure for information on Medicare Part D.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Catastrophic Protection

When you use network providers, your annual maximum for out-of-pocket expenses, deductibles, coinsurance, and copayments) for covered services is limited to the following:

CDHP

Self Only:

In-network: Your annual out-of-pocket maximum is $4,000.

Out-of-network: Your annual out-of-pocket maximum is $5,000.

Self Plus One:

In-network: Your annual out-of-pocket maximum is $6,850.

Out-of-network: Your annual out-of-pocket maximum is $10,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is $6,850.

Out-of-network: Your annual out-of-pocket maximum is $10,000.

Value Plan

Self Only:

In-network: Your annual out-of-pocket maximum is $5,000.

Out-of-network: Your annual out-of-pocket maximum is $5,000.

Self Plus One:

In-network: Your annual out-of-pocket maximum is $6,850.

Out-of-network: Your annual out-of-pocket maximum is $10,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is $6,850.

Out-of-network: Your annual out-of-pocket maximum is $10,000.

However, certain expenses under both options do not count towards your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum. Refer to Section 4.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan. See pages 65 and 107.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs. See pages 67 and 110.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are generally covered by the clinical trials. This Plan does not cover these costs. See pages 67 and 110.

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. See page 30.

Copayment A copayment is the fixed amount of money you pay when you receive covered services. See page 29.

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services Care we provide benefits for, as described in this brochure.

Custodial care Any type of care provided according to Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; or c) is a level such that you have reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Custodial care includes any type of care where the primary purpose is to attend to your daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples include assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of noninfected wounds, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by you, the general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in our sole determination, is based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, or convalescent care. Custodial care that lasts 90 days or more is sometimes known as long term care. Custodial care is not covered.

Deductible A deductible is the fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.

Detoxification The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

Emergency care An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Experimental or investigational services

Services or supplies that are, as determined by us, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

Also known as medically necessary or medically necessary services. “Medically necessary" means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

- In accordance with generally accepted standards of medical practice; and,
- Clinically appropriate in accordance with generally accepted standards of medical practice in terms of type, frequency, extent, site and duration, and considered effective for the illness, injury or disease; and,
- Not primarily for the convenience of you, or for the physician or other health care provider; and,
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

For these purposes, “generally accepted standards of medical practice,” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Network provider plans determine their allowances in different ways. We determine our allowance as follows:

- Network Providers - we negotiate rates with doctors, dentists and other health care providers to help save you money. We refer to these providers as “Network Providers". These negotiated rates are our Plan allowance for network providers. We calculate a member’s coinsurance using these negotiated rates. The member is not responsible for amounts that are billed by network providers that are greater than our Plan allowance.

- Non-Network Providers - Providers that do not participate in our networks are considered non-network providers. Because they are out of our network, we pay for out-of-network services based on an out-of-network Plan allowance. Here is how we figure out the Plan allowance.

We get information from Fair Health. Fair Health is a source for transparent, current and reliable health care charge information. It is a national, independent not-for-profit corporation that offers unbiased data products and services to consumers, the health care community, employers, unions, government agencies, policy members and researchers. Health plans send Fair Health copies of claims for services they receive from providers. The claims include the date and place of service, the procedure code, and the provider's charge. Fair Health combines this information into databases that show how much providers charge for just about any service in any zip code. Providers' charges for specific procedures are grouped in percentiles from low to high. We use the 80th percentile to calculate how much to pay for out of network services. Payment of the 80th percentile means 80 percent of charges in the database are the same or less for that service in a particular zip code. We would use this 80th percentile amount as the Plan allowance. We use the Plan allowance when calculating a member's coinsurance amount. The member would be responsible for any amounts billed by the non-network provider that are above this Plan allowance, plus their coinsurance amount.

Note: See page 30 of this brochure and www.aetnafeds.com for examples of member cost sharing for procedures in and out of network.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims were treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Precertification Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or you. It also allows Aetna to coordinate your transition from the inpatient setting to the next level of care (discharge planning), or to register you for specialized programs like disease management, case management, or our prenatal program. In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments.

Certain health care services, such as hospitalization or outpatient surgery, require precertification with Aetna to ensure coverage for those services. When you are to obtain services requiring precertification through a participating provider, this provider should precertify those services prior to treatment.

Note: Since this Plan pays out-of-network benefits and you may self-refer for covered services, it is your responsibility to contact Aetna to precertify those services which require precertification. You must obtain precertification for certain types of care rendered by non- network providers to avoid a reduction in benefits paid for that care.

Preventive care Health care services designed for prevention and early detection of illnesses in average risk people, generally including routine physical examinations, tests and immunizations.

Reimbursement	A carrier's pursuit of a recovery is a covered individual that has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Respite care	Care furnished during a period of time when your family or usual caretaker cannot, or will not, attend to your needs. Respite care is not covered.
Rollover	Any unused, remaining balance in your CDHP Medical Fund or Dental Fund at the end of the calendar year may be rolled over to subsequent years.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a worker's compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Urgent care	Covered benefits required in order to prevent serious deterioration of your health that results from an unforeseen illness or injury if you are temporarily absent from our service area and receipt of the health care service cannot be delayed until your return to our service area.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-888/238-6240. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and we refer to Aetna Life Insurance Company.
You	You refers to the enrollee and each covered family member.

Consumer Driven Health Plan (CDHP) Definitions

Calendar year deductible	Your calendar year deductible is $1,000 for Self only, $2,000 for Self Plus One, or $2,000 for Self and Family enrollment.
Consumer Driven Health Plan	A network provider plan under the FEHB that offers you greater control over choices of your health care expenditures.
Dental Fund (Consumer Driven Health Plan)	Your Dental Fund is an established benefit amount which is available for you to use to pay for covered dental expenses. You determine how your Dental Fund will be spent and any unused amount at the end of the year will be rolled over in subsequent year(s).
Medical Fund (Consumer Driven Health Plan)	Your Medical Fund is an established benefit amount which is available for you to use to pay for covered hospital, medical and pharmacy expenses. All of your claims will initially be deducted from your Medical Fund. Once you have exhausted your Medical Fund, and have satisfied your deductible, Traditional medical coverage begins. The Medical Fund is not a cash account and has no cash value. It does not duplicate other coverage provided by this brochure. It will be terminated if you are no longer covered by this Plan. Only eligible expenses incurred while covered under the Plan will be eligible for reimbursement subject to timely filing requirements. Unused Medical Funds are forfeited.

Section 11. Other Federal Programs

Please note, the following programs are not part of our FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose Self Only, Self Plus One, or Self and Family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,550 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible out-of-pocket (such as copayments, deductibles, prescriptions, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877/FSAFEDS (1-877/372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800/952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental and www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337), (TTY: 1-800-843-3557), or visit www.ltcfeds.com.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Notes

Summary of benefits for the Aetna HealthFund CDHP Plan - 2016

- **Do not rely on this chart alone**. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- For the Consumer Driven Health Plan (CDHP), your health charges are applied to your Medical Fund ($1,000 for Self Only, $2,000 for Self Plus One, and $2,000 for Self and Family) plus rollover amounts. Once your Medical Fund has been exhausted, you must satisfy your calendar year deductible, $1,000 for Self Only, $2,000 for Self Plus One, and $2,000 for Self and Family. You pay any difference between our allowance and the billed amount if you use a non-network physician or other health care professional. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

CDHP Benefits	You Pay	Page
In-network medical and dental preventive care	Nothing at a network provider	38
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	49
In-network Teladoc provider consult (Teladoc is not available for service in Missouri, Idaho and Arkansas)	$40 per consultation	49
Services provided by a hospital:		
• Inpatient	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	69
• Outpatient	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	70
Emergency benefits:	In-network: 15% of our Plan allowance Out-of-network: 15% of our Plan allowance and any difference between our allowance and the billed amount.	72
Mental health and substance abuse treatment:	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	74
Prescription drugs:		
• After your deductible has been satisfied, your copayment will apply.		77

CDHP Benefits (cont.)	You Pay	Page
• Retail pharmacy	In-network: For up to a 30-day supply: $10 per generic formulary; $35 per brand name formulary drug; $75 per non-formulary (generic or brand name); and Out-of-network (retail pharmacies only): 40% plus the difference between our Plan allowance and the billed amount	79
• **Specialty Medications:** For up to a 30-day supply per prescription unit or refill	Preferred: 50% per covered specialty drug up to a $250 maximum Non-preferred: 50% per covered specialty drug up to $500 maximum	80
• Mail order (available in-network only)	For a 31-day up to a 90-day supply: Two copays	79
Dental care: Dental Fund of $300 for Self Only or $600 for Self Plus One or Self and Family	In-network: After your Dental Fund has been exhausted, the negotiated rates offered by participating network PPO dentists. Out-of-network: After your Dental Fund has been exhausted, all charges.	45
Vision care: In-network (only) preventive care benefits.	Nothing	39
Vision care: Corrective eyeglasses and frames or contact lenses (hard or soft).	Nothing up to your available Medical Fund balance. All charges if Medical Fund balance is exhausted.	42
Special features: Flexible benefits option**,** Aetna Navigator, Informed Health Line, and Services for the deaf and hearing-impaired	Contact Plan	126
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after $4,000/Self Only enrollment, $6,850/Self Plus One enrollment, or $6,850/Self and Family enrollment per year. Out-of-network: Nothing after $5,000/Self Only enrollment, $10,000/Self Plus One enrollment, or $10,000/Self and Family enrollment per year. Some costs do not count toward this protection. Your deductible counts toward your out-of-pocket maximum.	31

Summary of benefits for the Value Plan - 2016

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Value Plan Benefits	You Pay	Page
In-network medical preventive care	Nothing	86
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In-network: $25 per primary care physician (PCP) visit, $40 per specialist visit Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	91
In-network Teladoc provider consult (Teladoc is not available for service in Missouri, Idaho and Arkansas)	$40 per consultation	91
Services provided by a hospital:		
• Inpatient	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	111
• Outpatient	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	112
Emergency benefits:	In-network: 20% of our Plan allowance Out-of-network: 20% of our Plan allowance and any difference between our allowance and the billed amount.	114
Mental health and substance abuse treatment:	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	116
Prescription drugs:		119
• Retail pharmacy	Retail pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered generic formulary drug; 30% per covered brand name formulary drug up to a $600 maximum;	121

Value Plan Benefits (cont.)	You Pay	Page
• Retail pharmacy	50% per covered non-formulary (generic or brand name) drug up to a $600 maximum. **Out-of-network (retail pharmacies only): (Out-of-network deductible applies)** 50% plus the difference between our Plan allowance and the billed amount.	121
• **Specialty Medications:** For up to a 30-day supply per prescription unit or refill	Preferred: 50% per covered specialty drug up to a $600 maximum Non-preferred: 50% per covered specialty drug up to $1,200 maximum	123
• Mail order (available in-network only)	For a 31-day up to a 90-day supply per prescription or refill: $20 per covered generic formulary drug 30% per covered brand name formulary drug up to a $1,200 maximum; and 50% per covered non-formulary (generic or brand name) drug up to a $1,200 maximum.	122
Dental care:	No benefit	125
Vision care: In-network (only) preventive care benefits.	Nothing	87
Special features: Flexible benefits option, Aetna Navigator, Informed Health Line, and Services for the deaf and hearing-impaired	Contact Plan	126
Protection against catastrophic costs (out-of-pocket maximum)**:**	In-network: Nothing after $5,000/Self Only enrollment, $6,850/Self Plus One enrollment, or $6,850/Self and Family enrollment per year. Out-of-network: Nothing after $5,000/Self Only enrollment, $10,000/Self Plus One enrollment, or $10,000/Self and Family enrollment per year. Some costs do not count toward this protection. Your deductible counts toward your out-of-pocket maximum.	32

2016 Rate Information for the Aetna HealthFund CDHP / Aetna Value Plan

For 2016 health premium information, please see: http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.