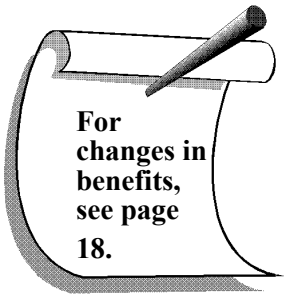
Aetna HealthFund®

http://www.aetnafeds.com

2012

An individual practice plan with a consumer driven health plan option and a high deductible health plan option

Serving the following states: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming



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 13-17 for requirements.

Please check the 2012 Guide to Federal Benefits for NCQA Accreditation

Enrollment codes for this Plan:

221 Consumer Driven Health Plan (CDHP) – Self Only

222 Consumer Driven Health Plan (CDHP) – Self and Family

224 High Deductible Health Plan (HDHP) – Self Only

225 High Deductible Health Plan (HDHP) – Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-828

Important Notice from Aetna About

Our Prescription Drug Coverage and Medicare

OPM has determined that Aetna HealthFund 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. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit 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 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'll 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 15th through December 7th) 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.

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Introduction

This brochure describes the benefits you can receive of Aetna Life Insurance Company under our contract (CS 2900) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. 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 oral 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. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefits are effective January 1, 2012, and changes are summarized on page 18. Rates are shown at the end of this brochure.

**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 first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

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.

- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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

202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100

- 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 that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- 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 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

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.

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 reduce medical errors that should never happen called "Never Events". When a Never Event occurs neither your FEHB plan nor you will incur costs to correct the medical error. Please see our policy statement on Never Events at www.aetnafeds.com.

Section 1. Facts about the Consumer Driven Health Plan (CDHP) and High Deductible Health Plan (HDHP)

This Plan is an individual practice plan offering you a choice of a Consumer Driven Health Plan (CDHP) or a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. CDHPs deliver the best of both worlds by blending traditional health coverage with a unique Fund benefit to help you pay for covered expenses. HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

CDHP

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply and what protections do not apply to a non-grandfathered health plan may be directed to us at 1/800-537-9384. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

HDHP

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply and what protections do not apply to a non-grandfathered health plan may be directed to us at 1/800-537-9384. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

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 2012, CDHP offers 100% in-network preventive care coverage, including dental. You have:

- A consumer-controlled annual Medical Fund of $1,000/Self Only or $2,000/Self and Family and an annual Dental Fund of $300/Self Only 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

Covered preventive medical and dental care services are paid at 100% if you use a network provider.

Deductible for your CDHP

Once you have exhausted your medical fund, the annual deductible of $1,000 for Self Only 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 out-of-pocket expenses for covered services, including deductible and coinsurance, cannot exceed $4,000 for Self Only enrollment or $8,000 for Self and Family enrollment for in-network services or $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment for out-of-network services.

General features of our High Deductible Health Plan (HDHP)

An HDHP is a health plan product that provides traditional health care coverage and a tax-advantaged way to help you build savings for future medical needs. An HDHP with an HSA or HRA is designed to give greater flexibility and discretion over how you use your health care benefits. As an informed consumer, you decide how to utilize your plan coverage with a high deductible and out-of-pocket expenses limited by catastrophic protection. And you decide how to spend the dollars in your HSA or HRA. You have:

- An HSA in which the Plan will automatically deposit $62.50 per month/Self Only or $125 per month/Self and Family.
- The ability to make voluntary contributions to your HSA of up to $2,300/Self Only or $4,650/Self and Family per year. If you are age 55 or older, you may also make a catch-up contribution of up to $1,000 for 2012.

You may consider:

- Using the most cost effective provider.
- Actively pursuing a healthier lifestyle and utilizing your preventive care benefit.
- Becoming an informed health care consumer so you can be more involved in the treatment of any medical condition or chronic illness.

The type and extent of covered services, and the amount we allow, may be different from other plans. Read our brochure carefully to understand the benefits and features of this HDHP. The IRS Web site at http://www.treas.gov/offices/public-affairs/hsa/faq.shtml has additional information about HDHPs.

Preventive care services for your HDHP

Covered preventive medical and dental care services are paid at 100% if you use in-network providers.

Annual deductible for your HDHP

The annual deductible of $1,500 for Self Only, $3,000 for Self & Family in-network and $2,500 for Self Only, $5,000 for Self & Family out-of-network, must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA) under HDHP

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term care coverage), not enrolled in Medicare, not have received VA benefits within the last three months, and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of your annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- For each month that you are enrolled in an HDHP and eligible for an HSA, the Plan will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA) under HDHP

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

You must notify us that you are ineligible for an HSA. If we determine that you are ineligible for an HSA, we will notify you by letter and provide an HRA for you.

Catastrophic protection for your HDHP

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles, copayments, and coinsurance cannot exceed $4,000 for Self Only enrollment, or $8,000 for Self and Family enrollment for in-network services or $5,000 for Self Only enrollment or $10,000 for Self and Family enrollment when you utilize out-of-network services.

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 123-125).

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 Web site 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 a 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 Web site (www.opm.gov/insure) 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 1-800-537-9384 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.

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 Web site 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. The enrollment code for all service areas is 22. Our Service Areas are:

Alabama, Most of Alabama – 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, Henry, Houston, Jackson, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Limestone, Lowndes, Macon, Madison, Marion, Marshall, Mobile, Monroe, Montgomery, Morgan, Perry, Pickens, Pike, Russell, St. Clair, Shelby, Sumter, Talladega, Tallapoosa, Tuscaloosa, Walker, Washington, Wilcox and Winston counties.

Alaska, Most of Alaska - Aleutians East, Aleutians West, Anchorage, Bethel, Bristol Bay, Denali, Dillingham, Fairbanks North Star, 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 and Yukon Koyukuk boroughs.

Arizona - All of Arizona.

Arkansas, Most of Arkansas - Arkansas, Baxter, Benton, Boone, Carroll, Clark, Clay, Cleburne, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Faulkner, Franklin, Fulton, Garland, Grant, 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 - Alameda, Amador, Butte, 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– All of Colorado.

Connecticut – All of Connecticut.

Delaware – All of Delaware.

District of Columbia – All of Washington, DC.

Florida, Most of Florida - Alachua, Baker, Bay, Bradford, Brevard, Broward, Charlotte, Citrus, Clay, Collier, Columbia, Duval, Escambia, Flagler, Gadsden, Gilchrist, Hernando, Highlands, Hillsborough, Holmes, Indian River, Jefferson, Lake, Lee, Leon, Levy, 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, Union, Volusia, Wakulla, Walton and Washington counties.

Georgia - All of Georgia

Hawaii - All of Hawaii.

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

Illinois, Most of Illinois - Alexander, Bond, Boone, Brown, Bureau, Calhoun, Champaign, Christian, Clark, Clay, Clinton, Coles, Cook, Crawford, De Kalb, Douglas, DuPage, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hardin, 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, Monroe, Montgomery, Morgan, Ogle, Peoria, Perry, Piatt, Pope, Pulaski, Randolph, Rock Island, St. Clair, Saline, Sangamon, Schuyler, Scott, Stark, Stephenson, Tazewell, Union, Vermilion, Wabash, Washington, Wayne, White, Whiteside, Will, Williamson, Winnebago and Woodford counties.

Indiana - All of Indiana.

Iowa - All of Iowa.

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

Kentucky, Most of Kentucky - 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, 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 - 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 – All of Maine.

Maryland – All of Maryland.

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

Michigan - All of Michigan.

Minnesota, Most of Minnesota - 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 - Adams, Alcorn, Amite, Attala, Benton, Bolivar, Calhoun, Carroll, Chickasaw, Claiborne, Clarke, Clay, Coahoma, Copiah, Covington, De Soto, Forrest, 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, 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 - 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, 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 -Beaverhead, Big Horn, Blaine, Broadwater, Carbon, Cascade, Chouteau, Custer, Daniels, Deer Lodge, Fallon, Fergus, Flathead, 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 - All of Nebraska

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

New Hampshire– All of New Hampshire.

New Jersey – All of New Jersey.

New Mexico, Albuquerque, Dona Ana and Hobbs areas - 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 - 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 - All of North Carolina.

North Dakota, Most of North Dakota - 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 - All of Ohio.

Oklahoma - All of Oklahoma

Oregon, Most of Oregon - 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 - All of Pennsylvania.

Rhode Island - All of Rhode Island.

South Carolina - All of South Carolina

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

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

Texas - All of Texas

Utah - Most of Utah - 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 - All of Vermont.

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

Washington, Most of Washington– 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 – 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 - All of Wisconsin.

Wyoming - 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. How we change for 2012

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

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public law 111-148.
- Your share of the non-Postal premium under both the Consumer Driven Health Plan (CDHP) and High Deductible Health Plan (HDHP) options will increase for Self Only and increase for Self and Family. See page 158.

Changes to our Consumer Driven Health Plan (CDHP) and our High Deductible Health Plan (HDHP)

- **Infertility services** - The Plan requires preauthorization of in network infertility services. In network benefits also requires members to access care from Aetna's select network of Plan infertility providers.
- **Durable Medical Equipment (DME)** - The Plan now covers certain bathroom equipment such as bathtub seats, benches, and lifts.
- **Mental health** - The Plan does not cover services in half-way houses.
- **Mental health** - The Plan does not cover educational services for treatment of behavioral disorders.
- **Service Area Expansions** - We expanded our service area as follows:
  - **Arkansas (Code 22)** - The Plan now covers the following counties in the State of Arkansas: Clay, Fulton and Randolph counties. (See page 13)
  - **California (Code 22)** - The Plan now covers the following counties in the State of California: Humboldt and Tehama counties. (See page 14)
  - **Illinois (Code 22)** - The Plan now covers the following counties in the State of Illinois: Edwards and Lawrence counties. (See page 14)
  - **Kansas (Code 22)** - The Plan now covers the following county in the State of Kansas: Doniphan county.(See page 14)
  - **Louisiana (Code 22)** - The Plan now covers the following counties in the State of Louisiana: Avoyelles, La Salle, Morehouse and Tensas counties and portions of Concordia county as defined by the following zip codes: 71326, 71334 and 71377. (See page 15)
  - **Mississippi (Code 22)** - The Plan now covers the following counties in the State of Mississippi: Clay, Issaquena, Leake, Smith, Wayne, Yalobusha and Yazoo counties. (See page 15)
  - **Missouri (Code 22)** - The Plan now covers the following counties in the State of Missouri: Atchison, Gentry, Harrison, Nodaway, Saint Clair and Worth counties. (See page 15)
  - **New York (Code 22)** - The Plan now covers the following counties in the State of New York: Franklin, Lewis, Otsego and Schoharie counties and portions of Saint Lawrence county defined by the following zip codes: 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 and 13699. (See page 16)
  - **Tennessee (Code 22)** - The Plan now covers the following counties in the State of Tennessee: Bledsoe and Hardin counties. (See page 16)
  - **Washington (Code 22)** - The Plan now covers the following county in the State of Washington: Wahkiakum county. (See page 17)
  - **West Virginia (Code 22)** - The Plan now covers the following counties in the State of West Virginia: Hampshire and Mineral counties. (See page 17)

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. If you enroll as 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 Web site 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 Web site 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 Web site 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, penile implants, and joint grafting procedures;
- Covered transplant surgery;
- Air ambulance and non-emergent ambulance transportation service;
- All home health care services including home IV and antibiotic therapy;
- Skilled nursing facilities, rehabilitation facilities, and inpatient hospice; and when full-time skilled nursing care is necessary in an extended care facility;
- 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, amytal interview, and hypnosis;

- Certain 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 studies such as CT scans, MRIs, MRAs, nuclear stress tests, and GI tract imaging through capsule endoscopy;
- Stereotactic radiosurgery;
- Somatosensory evoked potential studies;
- Cognitive skills development;
- Certain wound care such as hyperbaric oxygen therapy;
- Lower limb and torso prosthetics;
- Cochlear device and/or implantation;
- Percutaneous implant of nerve stimulator;
- High frequency chest wall oscillation generator system;
- BRCA genetic testing;
- In-network infertility services.

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 planned days of confinement.

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 48 hours 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 60 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 within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) 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.

- **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 two business days 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 48 hours after a vaginal delivery or 96 hours after 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.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten 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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: You pay 15% of our Plan allowance for in-network durable medical equipment under CDHP and 10% of our Plan allowance under the HDHP.

Copayments

A copay is the fixed amount of money you pay to the pharmacy when you receive certain services.

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.

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.

High Deductible Health Plan (HDHP)

You must satisfy your deductible before your Traditional medical coverage begins. For the HDHP, your annual deductible is $1,500 for a Self Only enrollment and $3,000 for Self and Family enrollment in-network and $2,500 for a Self Only enrollment and $5,000 for a Self and Family enrollment out-of-network. The Self and Family deductible can be satisfied by one or more members. The full Family deductible must be met for the plan of benefits to apply. There is no individual limit within the 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.

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 or $2,000 for Self and Family enrollment. The Self and Family deductible may be satisfied by one or more family members. Deductible limits must be satisfied before the Traditional Medical Plan benefits apply.

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.

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.

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.

Your catastrophic protection out-of-pocket maximum

Out-of-pocket maximums are the amount of out-of-pocket expenses that a Self Only or a Self and Family will have to pay in a plan year. Out-of-pocket maximums apply on a calendar year basis only.

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 and Family:

In-network: Your annual out-of-pocket maximum is $8,000.

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
- Copay expenses for prescription drugs
- 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

HDHP

Expenses applicable to out-of-pocket maximums – 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 HDHP, 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 and Family:

In-network: Your annual out-of-pocket maximum is $8,000.

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 allowance or maximum benefit limitations or expenses not covered under the Traditional medical coverage
- 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 18 for how our benefits changed this year and pages 154-155 for a benefits summary.

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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 at our Web site 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 / $10,000 Self and Family), 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 2012, the Plan provides $1,000 for a Self Only 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.

  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.

  The Plan also provides an annual Dental Fund for each enrollment. Each year, the Plan provides $300 for a Self Only 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 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 or $8,000 for Self and Family enrollment. If you use non-network providers, your out-of-pocket maximum is $5,000 for Self Only or $10,000 for Self and Family enrollment. 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.
  - Gather health-related information from our award-winning Aetna InteliHealth® Web site, one of the most comprehensive health sites available today.

  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.
  - The Price-A-Medical Procedure℠ tool to compare network physician fees for select services to typical fees outside the network.
  - Estimate the Cost of Care℠ that allows you to compare the estimated average costs for 200 different health care services in your area.
  - Price-A-Dental Procedure℠ tool to compare network dental fees for select services with typical fees outside the network.
  - Price-A-Drug℠ tool to estimate the cost of your prescription if obtained at a participating retail or mail order pharmacy.
  - 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, listed below: • Blood tests (Based on American Medical Association guidelines) • Routine urine tests • Total Blood Cholesterol • Fasting lipid profile • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older, and men age 40 and over who are at increased risk for prostate cancer • Colorectal Cancer Screening, including - Fecal occult blood test yearly starting at age 50 - Sigmoidoscopy screening — every five years starting at age 50 - Double contrast barium enema — every five years starting at age 50 - Colonoscopy screening — every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older • Abdominal Aortic Aneurysm Screening – ultrasonography, one screening for men between the age of 65 and 75 with a smoking history • Human papilloma virus (HPV) screening covered when done in combination with a Pap test for women ages 30 and older	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	In-network: Nothing at a network provider.

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay
Medical Preventive Care, adult (cont.)	
- From age 40 to 64, one every calendar year - At age 64 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 24 months up to age 65 - One exam every 12 months 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 for those 19 to 64 years of age, with a booster once every 10 years. For 65 and above, a tetanus-diphtheria booster is still recommended every 10 years. - Influenza vaccine, annually - Varicella (chicken pox) vaccine for all persons age 19 to 49 years without evidence of immunity to varicella - Pneumococcal vaccine, age 65 and over - Human papilloma virus (HPV) vaccine for men and women age 18 through age 26 - Herpes Zoster (Shingles) vaccine for all persons age 60 and older The following exams limited to: • 1 routine eye exam every 12 months • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • 1 routine hearing exam every 24 months Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 1-800/537-9384 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).
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. • 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.	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).

Medical Preventive Care, children - continued on next page

Benefit Description	You pay
Medical Preventive Care, children (cont.)	
• 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 1-800/537-9384 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).
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*
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 for $167 per month for 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 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 and Family enrollment of $2,000.

  If the subscriber begins the year under 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 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 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 2012 the Medical Fund is: • $1,000 per year for a Self Only enrollment, or; • $2,000 per year for a 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 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.
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 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 Web site 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 when you use a non-network dentist for diagnostic and preventive care. When you use a non-network for these services, the Dental Fund will pay first and your FEDVIP plan will pay second.
- 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 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 **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.

Dental fund - continued on next page

Benefit Description	You pay
Dental fund (cont.)	
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 • 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 and $2,000 for Self and Family enrollment. The 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 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 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 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 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 and $2,000 for Self and Family enrollment. The 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 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.
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI* • Ultrasound • Electrocardiogram and electroencephalogram (EEG) * Note: CAT Scans and MRIs require precertification, see "Services requiring our prior approval" on pages 20-21.	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…
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • 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 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: 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 births	*All charges*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures) • Surgically implanted contraceptives • 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: 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*

Benefit Description	You pay After the calendar year deductible…
Infertility services	
Infertility is defined as the inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination) for women under age 35, and 6 months of unprotected intravaginal sexual relations (or 6 cycles of artificial insemination) for women age 35 and over. • Artificial insemination and monitoring of ovulation: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) Note: Coverage is only for 3 cycles (per lifetime). In-network benefits requires members to 1) access care from Aetna's select network of Plan Infertility providers and 2) obtain preauthorization from the Plan prior to services. Otherwise, out-of-network benefits will apply. You must contact the Infertility Case Manager at 1-800/575-5999. • Testing for diagnosis and surgical treatment of the underlying cause of infertility. • Oral fertility drugs Note: We cover oral fertility drugs 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.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer including, but not limited to, gamete GIFT and zygote ZIFT* - *Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physicianservices.* - *Services and supplies related to the above mentioned services, including sperm processing* • *Reversal of voluntary, surgically-induced sterility.* • *Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal* • *Injectable fertility drugs* • *Infertility treatment when the FSH level is 19 mIU/ml or greater on day 3 of menstrual cycle.* • *The purchase, freezing and storage of donor sperm and donor embryos.*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Allergy care	
• Testing and treatment • Allergy injection • Allergy serum	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: • *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 52. • 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. Note: We will only cover GHT when we preauthorize the treatment. Call 1-800/245-1206 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.
Physical and occupational therapies	
• Two consecutive months (60 consecutive visits) per condition per member per calendar year, beginning with the first day of treatment for the services of each of the following: - Qualified Physical therapists - Occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury, with the exception of autism or autism spectrum disorders. 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 rehabilitation is covered under Hospital/Extended Care Benefits. • Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome	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.

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies (cont.)	
Note: Physical therapy treatment of lymphedemas following breast reconstruction surgery is covered under 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*
Speech therapy	
• Two consecutive months (60 consecutive visits) per condition per member per calendar year Note: We only cover therapy to restore or improve speech when speech-language disorders are the result of a non-chronic disease or acute injury; or when speech delay is associated with a specifically diagnosable disease, injury, or congenital defect (e.g. cleft palate, cleft lip, etc). Autism and autism spectrum disorders are considered as congenital defects for the purpose of administering this 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.
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*

Benefit Description	You pay After the calendar year deductible…
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*
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	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.

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
• 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*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Contact Plan at 1-800/537-9384 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 stairglides, 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*

Benefit Description	You pay After the calendar year deductible…
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: 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* • *Services provided by a family member or resident in the member's home.* • *Services rendered at any site other than the member's home.* • *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	
No benefits - some examples of alternative medical treatments may include, but are not limited to, acupuncture, applied kinesiology, aromatherapy, biofeedback, craniosacral therapy, hair analysis and reflexology. See Section 5 Non-FEHB benefits available to Plan members for discount arrangements.	*All charges*

Benefit Description	You pay After the calendar year deductible…
Educational classes and programs	
Aetna Health Connections offers disease management for 34 conditions. Included are programs for: • Asthma • Cerebrovascular disease • Congestive heart failure (CHF) • Chronic obstructive pulmonary disease (COPD) • Coronary artery disease • Cystic Fibrosis • Depression • Diabetes • 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 smoking cessation counseling sessions per quit attempt and two 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 smoking cessation counseling sessions per quit attempt and two quit attempts per year. Nothing up to our Plan allowance for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence.

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 and $2,000 for Self and Family enrollment. The 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 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 that has persisted for at least 2 years 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 (e.g., tubal ligation, vasectomy) • Treatment of burns • Skin grafting and tissue implants	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 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*	*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	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.

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	
• 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* • *Surgeries related to sex transformation*	*All charges*
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*

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental / investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Lung: single/bilateral • Kidney • Liver • Pancreas; Pancreas/Kidney (simultaneous) • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis Intestinal transplants • Small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas	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.

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
  - Advanced Hodgkin's lymphoma with reoccurrence (relapsed)
  - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)
  - Acute myeloid leukemia
  - Advanced Myeloproliferative Disorders (MPDs)
	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 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 - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer* - Ependymoblastoma - Epithelial ovarian cancer - 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.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
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 reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (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 reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (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.
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	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.)	
- Beta Thalassemia Major - 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 (MSDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell anemia	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.
• Autologous Transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - 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	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.)	
- 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.	
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	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.)	
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* • *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 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 and $2,000 for Self and Family enrollment. The 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 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*
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*

Benefit Description	You pay After the calendar year deductible...
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 and $2,000 for Self and Family enrollment. The 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 services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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 and $2,000 for Self and Family enrollment. The 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 and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. 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 2 hours per day or six 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, amytal interview, and hypnosis
  - 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 1-800/537-9384. 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 or reasons for treatment plan 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	
When part of a treatment plan we approve, 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	
• *Services that are not part of a preauthorized approved treatment plan* • *Educational services for treatment of behavioral disorders* • *Services in half-way houses*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- 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.
- Your deductible is $1,000 for Self Only and $2,000 for Self and Family enrollment. The 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 prescribed under the Plan. Upon approval by the Plan, the prescription is good 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, dentist or licensed practitioner (as allowed by law) must write the prescription.
- **Where you can obtain them.** Any retail pharmacy can be used for up to a 30-day supply. Our mail order program can 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 Web site at www.aetnafeds.com to review our Formulary Guide or call 1-888-238-6240.

Prescription drug benefits-continued on next page

- **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.**
- **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 Web site 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 filling 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 75% 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.
- **Why use generic drugs?** 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, when available, most members see cost savings, without jeopardizing clinical outcome or compromising quality.
- **When you do have to file a claim.** Send your itemized bill(s) to: Aetna, Pharmacy Management, Claim Processing, P.O. Box 14024, Lexington, KY 40512-4024.

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. These specialty type drugs are called Aetna Specialty CareRx medications which include 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 2012 Aetna Specialty CareRx list or contact us at 1-800-537-9384 for a copy. Note that the medications and categories covered are subject to change.

- To request a printed copy of the Aetna Medication Formulary Guide, call 1-888-238-6240. The information in the Medication 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 Web site at www.aetnafeds.com for current Medication 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 • Contraceptive drugs and devices • Oral fertility 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	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 $60 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 $120 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 67, Specialty Drugs for more information.	Up to a 30 day supply per prescription or refill: $10 per covered generic formulary drug; $35 per covered brand name formulary drug; and $60 per covered non-formulary drug

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
Limited benefits: • Drugs to treat erectile dysfunction are limited up to 4 tablets per 30 day period.	**In-network:** 50%
• Imitrex (limited to 48 kits per calendar year)	$35/kit
• Depo-Provera is limited to 5 vials per calendar year Note: Rx copay only applies when purchased at pharmacy. If physician provides Depo-Provera, member is responsible for office visit cost-sharing.	$35 copay per vial
• One diaphragm per calendar year	$35 per diaphragm
	Out-of-network (retail pharmacies only): 40% plus the difference between our Plan allowance and the billed amount, except for drugs to treat sexual dysfunction which are 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* - *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)* - *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* - *Prophylactic drugs including, but no limited to, anti-malarials for travel* - *Injectable 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 48.) 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). 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, they you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Aetna IntelliHealth	InteliHealth is an award-winning website with a mission to empower people to live healthier lives. We do this by sharing consumer-friendly information and tools from trusted sources, such as Harvard Medical School and Columbia University College of Dental Medicine. Visitors will find a drug resource center, disease and condition management information, health risk assessments, daily health news and much more. Aetna InteliHealth is a subsidiary of Aetna and is funded by Aetna to the extent not funded by revenues from operations. Visit www.intelihealth.com today.
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: • Review eligibility and PCP selections • Print temporary ID cards • Download details about a claim such as the amount paid and the deductible • 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 Aetna Intelihealth and Healthwise® Knowledgebase • Check fund balances 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.

Special features-continued on next page

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. Through Informed Health Line, members also have 24-hour access to an audio health library – equipped with information on more than 2,000 health topics, and accessible on demand through any touch tone telephone. Topics are available in both English and Spanish. 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

High Deductible Health Plan Benefits

See page 18 for how our benefits changed this year and pages 156-157 for a benefits summary.

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Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP 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.

HDHP Section 5, which describes the HDHP 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 HDHP benefits, contact us at 1-888-238-6240 or at our Web site at www.aetnafeds.com.

Our HDHP option provides traditional health care coverage and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

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 87. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: in-network medical and dental preventive care; traditional medical coverage that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools, such as online, interactive health and benefits information tools to help you make more informed health decisions.

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

  The Plan covers preventive care services, such as periodic health evaluations (e.g., routine physicals), screening services (e.g., routine mammograms), well-child care, routine child and adult immunizations, and routine oral evaluations and cleaning of your teeth. These services are covered at 100% if you use a network provider. The services are described in Section 5, In-Network Medical, and Dental Preventive Care.

  You do not have to meet the deductible before using these services. This does not reduce your HRA nor do you need to use your HSA for in-network preventive care.

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

  After you have paid the Plan's deductible (In-network: $1,500 for Self Only enrollment and $3,000 for Self and Family enrollment or Out-of-network: $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment), we pay benefits under Traditional medical coverage described in Section 5. The Plan typically pays 90% for in-network care and 70% for out-of-network care.

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse benefits
  - Prescription drug benefits
  - Special features

- **Savings**

  Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 75 for more details).

Health Savings Accounts (HSA)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA benefits within the last three months, or do not have other health insurance coverage other than another high deductible health plan. In 2012, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $62.50 per month for a Self Only enrollment or $125 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $3,100 for Self Only enrollment and $6,250 for Self and Family enrollment for 2012. The IRS allows you to contribute up to $1,000 in catch-up contributions for 2012, if you are age 55 or older. See maximum contribution information on page 79. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying qualified medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- JP Morgan Chase Bank, N.A. has been selected by Aetna to provide debit card, checkbook and record-keeping services. Aetna remains custodian for the HSA accounts.
- Your contributions to the HSA are tax deductible.
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest or any investment gains through a choice of voluntary investment options.
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.) A link to this publication can also be found at www.aetnafeds.com.
- Your unused HSA funds and interest accumulate from year to year.
- It's portable – the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire.
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a Health Care Flexible Spending Account (HCFSA) (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

If we determine that you are ineligible for an HSA, we will notify you by letter and provide an HRA for you.

In 2012, we will give you an HRA credit of $750 per year for a Self Only enrollment and $1,500 per year for a Self and Family enrollment. Your HRA will be used to help pay for covered services that apply towards your health plan deductible and/or for certain qualified medical expenses that don't count toward the deductible. (See IRS publication 502 for a list of qualified medical expenses).

HRA features include:

- For our HDHP option, the HRA is administered by Aetna Life Insurance Company.
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credits carryover from year to year.
- HRA credit does not earn interest.
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $4,000 for Self Only or $8,000 for Self and Family enrollment. If you use non-network providers, your out-of-pocket maximum is $5,000 for Self Only or $10,000 for Self and Family enrollment. 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 HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

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

HDHP Section 5(h) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

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 HRA fund or HSA account balance and deductible balance or the status of a claim.
- Gather health-related information from our award-winning Aetna InteliHealth® Web site, one of the most comprehensive health sites available today.

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.
- The Price-A-Medical Procedure℠ tool to compare network physician fees for select services to typical fees outside the network.
- Estimate the Cost of Care℠ that allows you to compare the estimated average costs for 200 different health care services in your area.
- Price-A-Dental Procedure℠ tool to compare network dental fees for select services with typical fees outside the network.
- Price-A-Drug℠ tool to estimate the cost of your prescription if obtained at a participating retail or mail order pharmacy.

- 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. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Aetna Life Insurance Company, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). HSA will be administered by JPMorganChase Bank, N.A. Aetna remains custodian of the HSA accounts. Aetna Life Insurance Company Federal Plans PO Box 550 Blue Bell, PA 19422-0550 1-888-238-6240 www.aetnafeds.com	Aetna Life Insurance Company is the HRA fiduciary for this Plan. Aetna Life Insurance Company Federal Plans PO Box 550 Blue Bell, PA 19422-0550 1-888-238-6240 www.aetnafeds.com
Fees	There is no HSA set-up fee. The administrative fee is covered in the premium while the member is covered under the HDHP. When using a Chase or Bank One ATM, there are no ATM fees. However, certain banking fees may apply. You can find the fee schedule at the end of this section on page 83. If you are no longer covered under the HDHP, there is a $3 administrative fee that will be deducted from your HSA account every month.	None
Eligibility	You must: • Enroll in the Aetna HealthFund High Deductible Health Plan (HDHP) • Have no other health insurance coverage (does not apply to another HDHP plan, specific injury, accident, disability, dental, vision, or long term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received VA benefits in the last three months • Complete and return all banking paperwork	You must enroll in the Aetna HealthFund High Deductible Health Plan (HDHP). If you enroll in a HDHP during open season or in the month of January, your HRA will be funded up to the yearly maximum. If you enroll outside of open season or other than the month of January, the funding of your HRA will be prorated based on each full month in which you are enrolled in a HDHP.

Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.). You may contribute to your HSA by submitting an Aetna HSA deposit slip or setting up an electronic funds transfer from your checking or savings account up to the maximum allowed. The deadline for HSA contributions is April 15 following the year for which contributions are made. When making contributions for a previous tax year, use the Tax Year Designation Change for Contributions to HSA form. You can obtain additional HSA forms by logging into the Aetna Navigator Web site at www.aetnafeds.com.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• **Self Only enrollment**	For 2012, a monthly premium pass through of $62.50 will be made by the HDHP directly into your HSA each month.	For 2012, your HRA annual credit is $750 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2012, a monthly premium pass through of $125 will be made by the HDHP directly into your HSA each month.	For 2012, your HRA annual credit is $1,500 (prorated for mid-year enrollment).
Contributions/ credits	The maximum that can be contributed to your HSA is an annual combination of the HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the annual statutory dollar maximum, which is $3,100 for Self Only coverage and $6,250 for Self and Family coverage for 2012. **If you are age 55 or older, the IRS allows you to contribute up to $1,000 in catch-up contributions.** If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.

Contributions/ credits *(cont.)*	You are eligible to fund your account up to the maximum contribution limit set by the IRS, even if you have partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. • You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). • You are able to make a one-time, tax-free, irrevocable, trustee-to-trustee rollover from your IRA to your HSA. The amount that may be rolled over from an IRA to an HSA is limited to the amount of your maximum annual HSA contribution limit for the year in which the rollover is made. Any amount you rollover from an IRA will count towards your annual HSA contribution limit so you will need to make sure that the amount you transfer from your IRA combined with your other HSA contributions for the year do not exceed the annual HSA contribution limit. • HSAs earn tax-free interest (does not affect your annual maximum contribution). • Catch-up contribution discussed on page 79.	
• **Self Only enrollment**	You may make a voluntary annual maximum contribution of $2,350.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make a voluntary annual maximum contribution of $4,750.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit Card – The Debit Card must be activated in order to have access to HSA Funds, customer service and online information. • By check (if purchased).	For covered medical expenses under your HDHP, claims will be paid automatically by your HRA when claims are submitted to Aetna, if there is money available in your HRA.

Access funds *(cont.)*	• AutoDebit Option - Aetna HSA AutoDebit is a fast, easy and automatic way to pay out-of-pocket health expenses from your HSA. If you are a member of an Aetna HDHP and enrolled in an Aetna HSA you can elect to have money withdrawn directly from your HSA to pay for qualified out-of-pocket expenses, paying the doctor directly, without having to use your Aetna HSA Visa debit card or checks.	
Distributions/with-drawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. Your HSA is established the first of the month following the effective date of your enrollment in this HDHP. For most Federal enrollees (those not paid on a monthly basis), the HDHP becomes effective the first pay period in January 2012. If the HDHP is effective on a date other than the first of the month, the earliest date medical expenses will be allowable is the first of the next month. If you were covered under the HDHP in 2011 and remain enrolled in this HDHP, your medical expenses incurred January 1, 2012 or later, will be allowable. If you incur a medical expense between your HDHP effective date but before your HSA is effective, you will not be able to use your HSA to reimburse yourself for those expenses. Note: Plan contributions are typically deposited around the middle of each month. See IRS Publication 502, which you can access at www.aetnafeds.com, for a list of qualified eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. You must submit these expenses with a claim form (available on our website www.aetnafeds.com) for reimbursement. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of qualified eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed:	Funds are not available until: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change).

	- Your enrollment in this HDHP is effective (effective date is determined by your agency in accordance with the event permitting the enrollment change). - The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. - The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you. After the plan administrator receives enrollment and contributions from OPM and your HSA has been created by JPMorganChase and funded, the enrollee can withdraw funds up to the amount contributed for any expenses incurred on or after the date the HSA was initially established.	• The entire amount of your HRA will be available to you upon your enrollment in the HDHP. (The HRA amount will be pro rated based on the effective date of coverage.)
Account owner	FEHB enrollee	Aetna Life Insurance Company
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 78 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

Fees for Federal Employees Health Benefits Program

Fee Description	Fee
Monthly Account Maintenance	**No charge**
ATM Withdrawal *	**No charge**
ATM Balance Inquiry*	**No charge**
ATM/Point-of-Service Denial*	**No charge**
Returned Deposit Check	**$15.00 per returned deposit check**
Checkbook Checks	**$10.65 per book of 25 checks purchased**
Copies of Processed Checks	**$10.00 per check**
Checks Returned for Non-sufficient Funds	**$20.00 per returned check**
Stop Payment of Check	**$20.00 per stopped check**
Supplemental EFT** Contribution	**$5.00 per contribution*** **
Returned EFT Deposit	**$15.00 per EFT deposit return**
Foreign Currency Conversion	**2.5% of purchase amount**
Account Closing by Check	**No charge**
Cash Advance (over the counter cash withdrawal at a bank branch)	**$5.00 per withdrawal**
Replacement of Lost/Stolen HSA Debit Card	**$5.00 (expedited shipping will be an additional charge)**

* You may be charged an additional ATM usage fee if you use a non-Chase or Bank One ATM for any HSA transaction. Usage fees will vary by ATM operators.

**Electronic Funds Transfer (EFT)

***Fee only applies to one-time EFT withdrawls from your checking account. There is no fee for monthly EFT withdrawls from your checking account.

If you have an HSA

- **Contributions**

All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or through Electronic Fund Transfer deposits that are withdrawn from your personal bank accounts, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000 in 2012 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

Spouse catch-up contributions must be established in a separate HSA account from that of the employee. Please contact your plan administrator for details.

- **If you die**

If you do not have a named beneficiary and if you are married, it becomes your spouse's HSA; otherwise, it becomes part of your taxable estate.

- **Investment Options**

Participation in voluntary investment options is entirely optional and neither Aetna nor JPMorganChase Bank, N.A. is or will be acting in the capacity of a registered investment advisor.

Account holders who exceed the minimum required balance of $2,000 in their HSA cash account, will have a number of different investment options to choose from in 2012 that will be offered by different organizations that have been selected by Aetna. Balances in these investment options may fluctuate up or down and will not be insured by the FDIC or other government agencies.

There is a monthly $2.50 administrative fee for maintaining the optional HSA Investment Account. This fee will be debited from your HSA Cash Account. There is also a phone-assisted trading Fee of $10.00/call. The $10.00 phone assisted trading fee will be waived for the initial transfer of at least $2,000 from your HSA Cash Account. Any subsequent phone-assisted transaction a Trading Fee of $10.00 will apply. Please see www.aetnafeds.com for other HSA investment account fees.

Aetna will make available HSA investment options, as defined below, to account holders who exceed the minimum required balance of $2,000 in their HSA cash account. (Investment options are subject to change).

These funds are distributed through JPMorgan Distribution Services, Inc., and are not offered or insured by Aetna or JPMorganChase Bank, N.A. (JPMC). Participation in these options will be entirely optional, and neither Aetna nor JPMC is or will be acting in the capacity of a registered investment advisor with respect to these options. Balances in the funds may fluctuate and will not be insured by the FDIC or other government agency.

Investment Options

- Principal Midcap Blend Fund
- Russell LifePoints®
  - Conservative Strategy
  - Moderate Strategy
  - Growth Strategy Funds
- JPMorgan Prime Money Market Fund
- JPMorgan Core Bond Fund A
- JPMorgan Equity Index Fund A
- JPMorgan Small Cap Equity Fund A

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, physician prescribed over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800/829-3676, or visit the IRS Web site at www.irs.gov and click on "Forms and Publications". Note: Although physician prescribed over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You can view account activity such as the "premium pass through," withdrawals, and interest earned on your account, as well as account balances online on Aetna Navigator. You can also request a paper monthly activity statement at no additional charge.

- **Minimum reimbursements from your HSA**

  There is no minimum withdrawal or distribution amount.

If you have an HRA

- **Why an HRA is established**

  If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish and HRA for you. You must tell us if you are or become ineligible to contribute to an HSA.

- **How an HRA differs**

  Please review the chart beginning on page 78 which details the differences between an HRA and HSA. The major differences are:

  - you cannot make contributions to an HRA
  - funds are forfeited if you leave the HDHP
  - an HRA does not earn interest

- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include 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.

Section 5. Medical and Dental Preventive Care

Important things you should keep in mind about these medical and dental 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 and dental 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.
- Note that the in-network preventive care paid under this Section does NOT count against or use up your HSA or HRA.

Benefit Description	You pay	
Medical Preventive Care, adult	**HSA**	**HRA**
Routine screenings, listed below: • Blood tests (Based on American Medical Association guidelines.) • Routine urine tests • Total Blood Cholesterol • Fasting lipid profile • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older and men age 40 and over who are at increased risk for prostate cancer • Colorectal Cancer Screening, including: - Fecal occult blood test yearly starting at age 50 - Sigmoidoscopy screening — every five years starting at age 50 - Double contrast barium enema — every five years starting at age 50 - Colonoscopy screening — every 10 years starting at age 50 • Abdominal Aortic Aneurysm Screening – Ultrasonography, one screening for men between the age of 65 and 75 with a smoking history • Routine annual digital rectal exam (DRE) for men age 40 and older • Human papilloma virus (HPV) screening covered when done in combination with a Pap test for women ages 30 and older • Routine mammogram - covered for women age 35 and older, as follows:	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 30% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay	
Medical Preventive Care, adult (cont.)	**HSA**	**HRA**
- From age 35 through 39, one during this five year period - From age 40 to 64, one every calendar year - At age 64 and older, one every 2 consecutive calendar years • Routine physicals: - One exam every 24 months up to age 65 - One exam every 12 months 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 for those 19 to 64 years of age, with a booster once every 10 years. For 65 and above, a tetanus-diphtheria booster is still recommended every 10 years. • Influenza vaccine, annually • Varicella (chicken pox) vaccine for all persons age 19 to 49 years without evidence of immunity to varicella • Pneumococcal vaccine, age 65 and over • Human papillomavirus (HPV) vaccine for men and women age 18 through age 26 • Herpes Zoster (Shingles) vaccine for all persons age 60 and older The following exams and eyewear limited to: • 1 routine eye exam every 12 months • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • 1 routine hearing exam every 24 months • Corrective eyeglasses and frames or contact lenses (hard or soft) per 24-month period up to a Plan allowance of $100. Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 1-800/537-9384 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 30% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.
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*	*All charges*

Benefit Description	You pay	
Medical Preventive Care, children	**HSA**	**HRA**
• 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. • 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. • 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 Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 1-800/537-9384 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 30% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.
Not covered: • *Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*	*All charges*
Dental Preventive Care	**HSA**	**HRA**
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)	In-network: Nothing at a network dentist Out-of-network: All charges	In-network: Nothing at a network dentist Out-of-network: All charges

Dental Preventive Care - continued on next page

Benefit Description	You pay	
Dental Preventive Care (cont.)	**HSA**	**HRA**
Note: Participating network PPO dentists may offer members services at discounted fees. Discounts may not apply in all states. So, you may be 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 1-800/537-9384.	In-network: Nothing at a network dentist Out-of-network: All charges	In-network: Nothing at a network dentist Out-of-network: All charges
Not covered: We offer no other dental benefits other than those shown above.	*All charges*	*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 and dental preventive care is covered at 100% (see pages 87-90) and is not subject to your calendar year deductible.
- The deductible is: In-network - $1,500 for Self Only enrollment and $3,000 for Self & Family enrollment or Out-of-Network - $2,500 per Self Only or $5,000 per Self and Family enrollment. The family deductible can be satisfied by one or more family members. You must satisfy your deductible before your Traditional medical coverage may begin.
- 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 $4,000 in-network and $5,000 out-of-network per person or $8,000 in-network and $10,000 out-of-network per family enrollment 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	**HSA**	**HRA**
You must satisfy your deductible before your Traditional medical coverage begins. The 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: $1,500 for Self Only enrollment and $3,000 for Self & Family enrollment or Out-of-Network: $2,500 per Self Only enrollment or $5,000 per Self and Family enrollment. You can use your HSA to help satisfy your deductible.	100% of allowable charges until you meet the deductible: In-network: $1,500 for Self Only enrollment and $3,000 for Self & Family enrollment or Out-of-Network: $2,500 per Self Only enrollment or $5,000 per Self and Family enrollment. Your HRA Fund counts towards your deductible. Your HRA fund ($750/$1,500) is used first. Then you must pay the remainder of the deductible (e.g. In-network $1,500/$3,000) out-of-pocket i.e., $750/$1,500.

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 - $1,500 for Self Only enrollment and $3,000 for Self & Family enrollment or Out-of-Network - $2,500 for Self Only enrollment and $5,000 for Self & Family enrollment each calendar year. The 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.

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 family enrollment • In an urgent care center for a routine service • During a hospital stay • In a skilled nursing facility • At home	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
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 20-21.	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible…
Maternity care	
• Complete maternity (obstetrical) care, such as: • Prenatal care • 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 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: 10% of our Plan allowance Out-of-network: 30% 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: • Voluntary sterilization (See *Surgical procedures* (Section 5b) • Surgically implanted contraceptives • 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: 10% of our Plan allowance Out-of-network: 30% 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*

Benefit Description	You pay After the calendar year deductible…
Infertility services	
Infertility is defined as the inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination) for women under age 35, and 6 months of unprotected intravaginal sexual relations (or 6 cycles of artificial insemination) for women age 35 and over. Diagnosis and treatment of infertility such as: Artificial insemination and monitoring of ovulation: • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI) Note: Coverage is only for 3 cycles (per lifetime). In-network benefits requires members to 1) access care from Aetna's select network of Plan Infertility providers and 2) obtain preauthorization from the Plan prior to services. Otherwise, out-of-network benefits will apply. You must contact the Infertility Case Manager at 1-800/575-5999. • Testing for diagnosis and surgical treatment of the underlying cause of infertility. • Oral fertility drugs Note: We cover oral fertility drugs under the prescription drug benefit.	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer including, but not limited to, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *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* • *Reversal of voluntary, surgically-induced sterility* • *Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal* • *Injectable fertility drugs* • *Infertility treatment when the FSH level is 19 mIU/ml or greater on day 3 of menstrual cycle* • *The purchase, freezing and storage of donor sperm and donor embryos*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Allergy care	
• Testing and treatment • Allergy injections • Allergy serum	In-network: 10% of our Plan allowance Out-of-network: 30% 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. Note: We will only cover GHT when we preauthorize the treatment. Call 1-800/245-1206 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: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Physical and occupational therapies	
Two consecutive months (60 consecutive days) per condition per member per calendar year, beginning with the first day of treatment for the services of each of the following: • Qualified Physical therapists • Occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury, with the exception of autism or autism spectrum disorders. 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 rehabilitation is covered under Hospital/Extended Care Benefits. • Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Physical and occupational therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies (cont.)	
Note: Physical therapy treatment of lymphedemas following breast reconstruction surgery is covered under Reconstructive surgery benefit - see section 5(b).	In-network: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Long-term rehabilitative therapy	*All charges*
Speech therapy	
• Two consecutive months (60 consecutive days) per condition per member per calendar year Note: We only cover therapy to restore or improve speech when speech-language disorders are the result of a non-chronic disease or acute injury; or when speech delay is associated with a specifically diagnosable disease, injury, or congenital defect (e.g. cleft palate, cleft lip, etc). Autism and autism spectrum disorders are considered as congenital defects for the purpose of administering this benefit.	In-network: 10% of our Plan allowance Out-of-network: 30% 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 (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: 10% of our Plan allowance Out-of-network: 30% 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*

Benefit Description	You pay After the calendar year deductible…
Vision services (testing, treatment, and supplies)	
• Treatment of eye diseases and injury	In-network: 10% of our Plan allowance Out-of-network: 30% 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: 30% 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*
Foot care	
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 10% of our Plan allowance Out-of-network: 30% 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.	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
• Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.)	In-network: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% 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*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Contact Plan at 1-800/537-9384 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: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Home modifications such as stairglides, 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*

Benefit Description	You pay After the calendar year deductible…
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 heatlh 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: Home health services must be precertified by your attending Physician.	In-network: 10% of our Plan allowance Out-of-network: 30% 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* • *Services rendered when the member is not homebound because of illness or injury* • *Private duty nursing services*	*All charges*
Chiropractic	
No benefits	*All charges*
Alternative medicine treatments	
No benefits - some examples of alternative medical treatments may include, but are not limited to, acupuncture, applied kinesiology, aromatherapy, biofeedback, craniosacral therapy, hair analysis and reflexology. See Section 5 Non-FEHB benefits available to Plan members for discount arrangements.	*All charges*

Benefit Description	You pay After the calendar year deductible…
Educational classes and programs	
Aetna Health Connections offers disease management for 34 conditions. Included are programs for: • Asthma • Cerebrovascular disease • Congestive heart failure (CHF) • Chronic obstructive pulmonary disease (COPD) • Coronary artery disease • Cystic Fibrosis • Depression • Diabetes • 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 smoking cessation counseling sessions per quit attempt and two 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 smoking cessation counseling sessions per quit attempt and two quit attempts per year. Nothing up to our Plan allowance for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence.

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 - $1,500 for Self Only enrollment and $3,000 for Self & Family enrollment or Out-of-Network - $2,500 for Self Only enrollment and $5,000 for Self & Family enrollment each calendar year. The 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 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 that has persisted for at least 2 years 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: 10% of our Plan allowance Out-of-network: 30% 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 (e.g., tubal ligation, vasectomy) • Treatment of burns • Skin grafting and tissue implants	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
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*	*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	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	
• 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: 10% of our Plan allowance Out-of-network: 30% 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* • *Surgeries related to sex transformation*	*All charges*
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: 10% of our Plan allowance Out-of-network: 30% 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*

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Lung: single/bilateral • Kidney • Liver • Pancreas; Pancreas/Kidney (simultaneous) • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis Intestinal transplants • Small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver, stomach, and pancreas	In-network: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
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 measure many features of leukemia or lymphoma cells to gain insight into its aggressiveness or likelihood of response to various therapies. Some of these include 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. These analyses may allow physicians to determine which diseases will respond to chemotherapy or which ones will not respond to chemotherapy and may rather respond to transplant. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia	In-network: 10% of our Plan allowance Out-of-network: 30% 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 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 - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer* - Ependymoblastoma - Epithelial ovarian cancer - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Pineoblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors *Approved clinical trial necessary for coverage.	In-network: 10% of our Plan allowance Out-of-network: 30% 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.)	
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 reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (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 reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma	In network: 10% of our Plan allowance Out-of-network: 30% 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	In-network: 10% of our Plan allowance Out-of-network: 30% 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.)	
- 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) - 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 - 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	In-network: 10% of our Plan allowance Out-of-network: 30% 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.)	
- Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	In-network: 10% of our Plan allowance Out-of-network: 30% 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 benfits 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.	
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	In-network: 10% of our Plan allowance Out-of-network: 30% 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.)	
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: 10% of our Plan allowance Out-of-network: 30% 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* • *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 provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 10% of our Plan allowance Out-of-network: 30% 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 - $1,500 for Self Only enrollment and $3,000 for Self & Family enrollment or Out-of-Network - $2,500 for Self Only enrollment and $5,000 for Self & Family enrollment each calendar year. The 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: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% 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 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: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% 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 - $1,500 for Self Only enrollment and $3,000 for Self & Family enrollment or Out-of-Network - $2,500 for Self Only enrollment and $5,000 for Self & Family enrollment each calendar year. The 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 out patient in a hospital, including doctors' services	In-network: 10% of our Plan allowance Out-of-network: 10% 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: 10% of our Plan allowance Out-of-network: 10% 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 services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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 - $1,500 for Self Only enrollment and $3,000 for Self & Family enrollment or Out-of-Network - $2,500 for Self Only enrollment and $5,000 for Self & Family enrollment each calendar year. The 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 and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. 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 2 hours per day or six 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, amytal interview, and hypnosis
  - 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 1-800/537-9384. 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 or reasons for treatment plan 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	
When part of a treatment plan we approve, 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: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% 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: 10% of our Plan allowance Out-of-network: 30% 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	
• *Services that are not part of a preauthorized approved treatment plan* • *Educational services for treatment of behavioral disorders* • *Services in half-way houses*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the third page. Copayment 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 30%. 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.
- For prescription drugs and medications, you first must satisfy your deductible: In-network: $1,500 for Self Only enrollment and $3,000 for Self & Family enrollment or Out-of-Network $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section and is reduced by your HRA Fund, if applicable. While you are meeting this deductible, the cost of your prescriptions will automatically be deducted from your HRA Fund at the time of the purchase. If you are enrolled in the HSA, you will be responsible for the cost of the prescription. You may use your HSA debit card. 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 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 30% 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 prescribed under the Plan. Upon approval by the Plan, the prescription is good 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, dentist or licensed practitioner (as allowed by law) must write the prescription.
- **Where you can obtain them.** Any retail pharmacy can be used for up to a 30-day supply. Our mail order program can 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 Web site at www.aetnafeds.com to review our Formulary Guide or call 1-888-238-6240.

Prescription drug benefits-continued on next page

- **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.**
- **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 Web site 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, 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 filling 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 75% 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.
- **Why use generic drugs?** 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, when available, most members see cost savings, without jeopardizing clinical outcome or compromising quality.
- **When you do have to file a claim.** Send your itemized bill(s) to: Aetna, Pharmacy Management, Claim Processing, P.O. Box 14024, Lexington, KY 40512-4024.

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. These specialty type drugs are called Aetna Specialty CareRx medications which include 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 2012 Aetna Specialty CareRx list or contact us at 1-800-537-9384 for a copy. Note that the medications and categories covered are subject to change.

- To request a printed copy of the Aetna Medication Formulary Guide, call 1-888-238-6240. The information in the Medication 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 Web site at www.aetnafeds.com for current Medication 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 • Contraceptive drugs and devices • Oral fertility 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:** 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: 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 $60 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 $120 per covered non-formulary (generic or brand name) drug. **Out-of-network (retail pharmacies only):** 30% 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.	Up to a 30 day supply per prescription or refill: $10 per covered generic formulary drug; $35 per covered brand name formulary drug; and $60 per covered non-formulary drug

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
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 119, Specialty Drugs for more information.	Up to a 30 day supply per prescription or refill: $10 per covered generic formulary drug; $35 per covered brand name formulary drug; and $60 per covered non-formulary drug
Limited benefits: • Drugs to treat erectile dysfunction are limited up to 4 tablets per 30 day period. Note: Mail order is not available.	**In-network:** 50%
• Imitrex (limited to 48 kits per calendar year)	$35/kit
• Depo-Provera is limited to 5 vials per calendar year Note: Rx copay only applies when purchased at pharmacy. If physician provides Depo-Provera, member is responsible for office visit cost-sharing.	$35 copay per vial
• One diaphragm per calendar year	$35 per diaphragm
	Out-of-network (retail pharmacies only)**:** 30% plus the difference between our Plan allowance and the billed amount, except for drugs to treat sexual dysfunction which are 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* • *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)* • *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.* • *Prophylactic drugs including, but not limited to, anti-malarials for travel* • *Injectable fertility drugs* • *Compounded bioidentical hormone replacement (BHR) therapy that includes progesterone, testosterone and/or estrogen.* • *Compounded thyroid hormone therapy*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
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). 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 InteliHealth®	InteliHealth is an award-winning website with a mission to empower people to live healthier lives. We do this by sharing consumer-friendly information and tools from trusted sources, such as Harvard Medical School and Columbia University College of Dental Medicine. Visitors will find a drug resource center, disease and condition management information, health risk assessments, daily health news and much more. Aetna InteliHealth is a subsidiary of Aetna and is funded by Aetna to the extent not funded by revenues from operations. Visit www.intelihealth.com today.
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: • Review eligibility and PCP selections • 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 Aetna Intelihealth and Healthwise® Knowledgebase • Check HSA balances 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.

Special features-continued on next page

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. Through Informed Health Line, members also have 24-hour access to an audio health library – equipped with information on more than 2,000 health topics, and accessible on demand through any touch tone telephone. Topics are available in both English and Spanish. 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

Section 5(h). Health education resources and account management tools

Special features	Description
Health education resources	We keep you informed on a variety of issues related to your good health. Visit our Web site at www.aetnafeds.com or call Member Services at 1-888-238-6240 for information on: • Aetna Navigator® • Aetna InteliHealth Web site • Healthwise® Knowledge base • Informed Health® Line • Price-A-DrugSM tool • Hospital comparison tool and Estimate the Cost of Care tool • Price-A-Medical Procedure and Price-a-Dental Procedure tools • DocFind online provider directory
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through Aetna Navigator. You can access Navigator at www.aetnafeds.com. • Your balance will also be shown on your explanation of benefits (EOB) form. • You will receive an EOB after every claim. If you have an **HSA:** - You may also access your account online by going to Aetna Navigator at www.aetnafeds.com. If you have an **HRA:** - Your HRA balance will be available online through www.aetnafeds.com - Your balance will also be shown on your EOB form.
Consumer choice information	• As a member of this HDHP, you may choose any licensed provider. However, you will receive discounts when you see a network provider. Directories are available online by going to Aetna Navigator at www.aetnafeds.com • Pricing information for medical care is available at www.aetnafeds.com • Pricing information for prescription drugs is available at www.aetnafeds.com • Link to online pharmacy through www.aetnafeds.com • Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.aetnafeds.com
Care support	Patient safety information is available online at www.aetnafeds.com

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 InteliHealth®

InteliHealth is an award-winning website with a mission to empower people to live healthier lives. We do this by sharing consumer-friendly information and tools from trusted sources, such as Harvard Medical School and Columbia University College of Dental Medicine. Visitors will find a drug resource center, disease and condition management information, health risk assessments, daily health news and much more. Aetna InteliHealth is a subsidiary of Aetna and is funded by Aetna to the extent not funded by revenues from operations. Visit www.intelihealth.com today.

Aetna Vision℠ 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 13,000 providers 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 ℠ 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 HearPO® and includes access to over 1,600 participating locations. HearPO provides discounts on hearing exams, hearing services, hearing aid repairs, and choice of the latest technologies. Call HearPO customer service at 1-888-432-7464. Make sure the HearPO customer service representative knows you are an Aetna member. HearPO will send you a validation packet and you will receive the discounts at the point of purchase.

Aetna Fitness ℠ 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 ℠ Discount Program

Offers reduced rates on acupuncture, chiropractic care, massage therapy, and dietetic counseling through American Specialty Health Incorporated (ASH) and its subsidiaries. ASH also offers discounts on over-the-counter vitamins, herbal and nutritional supplements, and natural products. Through Vital Health Network, you can receive a discount on online consultations and information, please call Aetna Member Services at 1-800/537-9384.

Aetna Weight Management ℠ 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 Craig® weight loss programs 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 1-800/537-9384.

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 – things we don't 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 related to sex transformations.
- 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.

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 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 Web site 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:

Consumer Driven Health Plan(CDHP)/Health Reimbursement Arrangement(HRA)/ High Deductible Health Plan (HDHP)/Health Savings Account (HSA) and Health Reimbursement Arrangement (HRA)

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

Any withdrawals from your HSA must be done via your debit card, check, or Auto-Debit.

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.

Section 8. The disputed claims process

You may be able to 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.

Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or 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.
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 sent 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, Heatlhcare 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 sue, 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 sue 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 1-800/537-9384. We will hasten 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.

Section 9. Coordinating benefits with 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' guidelines.

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 Medicare's allowance. When we are the secondary payor, we pay the lessor of our allowance or the difference between the Medicare allowance and the amount paid by Medicare. We do not pay more than our allowance. You are still responsible for your copayment or coinsurance based on the amount left after Medicare payment.

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. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800/772-1213 (TTY 1-800/325-0778). 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. The notice will give you guidance on enrolling in Medicare Part D.

- **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.

You can find more information about how our plan coordinates benefits with Medicare by calling 1-800/537-9384.

- **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), but 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.

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

If you suffer an illness or injury for which another party may be responsible, the following subrogation and reimbursement rights in favor of your FEHB plan will apply.

The words "Third Party," "Any Party" or "Responsible Party" includes not only the insurance carrier(s) for the responsible party, but also any uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage or any other first party insurance coverage. The words "Member," "you" and "your" include anyone on whose behalf the Plan pays or provides any benefits.

You specifically acknowledge our right of subrogation. When we provide health care benefits for injuries or illnesses for which another responsible party is or may be responsible, we shall be subrogated to your rights of recovery against any responsible party to the extent of the full cost of all benefits provided by us. We may proceed against any responsible party with or without your consent.

You also specifically acknowledge our right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when we have provided health care benefits for injuries or illnesses for which another party is or may be responsible and you and/or your representative has recovered any amounts from the responsible party or any party making payments on the responsible party's behalf. By providing any benefit under this Plan, we are granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by us. Our right of reimbursement is cumulative with, and not exclusive of, our subrogation right and we may choose to exercise either or both rights of recovery.

You and your representatives further agree to:

- Notify us in writing within 30 days of when notice is given to any responsible party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illnesses sustained by you that may be the legal responsibility of another party; and
- Cooperate with us and do whatever is necessary to secure our rights of subrogation and/or reimbursement under this Plan; and
- Give us a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a responsible party to the extent of the full cost of all benefits provided by us associated with injuries or illnesses for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and
- Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due us as reimbursement for the full cost of all benefits provided by us associated with injuries or illnesses for which another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement and regardless of whether each payment will result in a recovery to the Member which is insufficient to make the Member whole or to compensate the Member in part or in whole for the damages sustained), unless otherwise agreed to by us in writing; and
- Do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by us; and
- Serve as a constructive trustee for the benefit of this Plan or any settlement or recovery funds received as a result of Third Party injuries.

We may recover the full cost of all benefits provided by us under this Plan without regard to any claim of fault on the part of you, whether by comparative negligence or otherwise. We may recover the full cost of all benefits provided by us under this Plan even if such payment will result in a recovery to you which is insufficient to make you whole or fully compensate you for your damages. No court costs or attorney fees may be deducted from Aetna's recovery, and Aetna is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by the Member to pursue the Member's claim or lawsuit against any Responsible Party without the prior express written consent of Aetna. In the event you or your representative fails to cooperate with us, you shall be responsible for all benefits paid by us in addition to costs and attorney's fees incurred by us in obtaining repayment.

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 when you use a non-network dentist for diagnostic and preventive care. 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, 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

This health plan covers care for clinical trials according to definitions listed below and as stated on specific pages of this brochure:

- 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 54 and 106.
- 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 57 and 109.

- 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. We do not cover these costs. See pages 57 and 109.

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 and Family:

In-network: Your annual out-of-pocket maximum is $8,000.

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

HDHP

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 and Family:

In-network: Your annual out-of-pocket maximum is $8,000.

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

- 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 54 and 106.
- 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 57 and 109.
- 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. We do not cover these costs. See pages 57 and 109.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 25.

Copayment

A copayment is the fixed amount of money you pay when you receive covered services. See page 25.

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 First Health. Health plans send First 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. First 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. Charges that fall in the middle are grouped into the 50th percentile. 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.

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.

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 or your HDHP HSA/HRA at the end of the calendar year may be rolled over to subsequent years.

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 1-800/537/9384. 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

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.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	Your calendar year deductible is $1,500 for Self only or $3,000 for Self and Family enrollment for In-Network services OR $2,500 for Self only or $5,000 for Self and Family enrollment for Out-of-Network services.
Health Savings Account (HSA)	An HSA is a special, tax-advantaged account where money goes in tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for qualified medical services.
Health Reimbursement Arrangement (HRA)	An HRA combines a Fund with a deductible-based medical plan with coinsurance limits. The HRA Fund pays first. Once you exhaust your HRA Fund, Traditional medical coverage begins after you satisfy your deductible. Your HRA Fund counts toward your deductible.
High Deductible Health Plan (HDHP)	An HDHP is a plan with a deductible of at least $1,150 for individuals and $2,300 for families for 2012, adjusted each year for cost of living.
Maximum HSA Contribution	For 2012, the annual statutory maximum contribution is $3,100 for Self Only enrollment and $6,250 for Self & Family enrollment.
Catch-Up HSA Contribution	For 2012, individuals age 55 or older may make a catch up contribution of $1,000.
Premium Contribution to HSA/HRA	The amount of money we contribute to your HSA on a monthly basis. In 2012, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $62.50 per month for Self Only and $125 per month for Self and Family. If you have the HRA, and are a current member or enrolled during Open Season, we contribute $750 for Self only or $1,500 for Self and Family enrollments at the beginning of the year. If you enroll after Jaunuary 1, 2012, the amount contributed will be on a prorated basis.

Section 11. 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.

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

See www.opm.gov/insure/health 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 who 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 a *Guide to Federal Benefits,* 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 and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. 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 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 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 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.

- Family member coverge

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.

Children	Coverage
Natural, 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.

- **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 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 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 and Family coverage 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 and Family 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 and Family 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. 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 2012 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 2011 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), or a conversion policy (a non-FEHB individual policy).

- **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 RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal 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 job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Other Federal Programs

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. The result can be a discount of 20% to more than 40% on services/products you 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 $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, 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) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **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 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) which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) 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 and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **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 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and 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/insure/vision *and* www.opm.gov/insure/dental. 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.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state hight risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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

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Notes

Summary of benefits for the CDHP of the Aetna HealthFund Plan-2012

- **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 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 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	32-34
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.	40
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.	58
• 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.	59
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.	61
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.	63
Prescription drugs:		
• After your deductible has been satisfied, your copayment will apply.		66
• Retail pharmacy	In-network: For up to a 30-day supply: $10 per generic formulary; $35 per brand name formulary; and $60 per nonformulary (generic or brand name)	67

Summary of benefits continued on next page

CDHP Benefits (cont.)	You Pay	Page
• Retail pharmacy (continued)	Out-of-network (retail pharmacy only): 40% plus the difference between our Plan allowance and the billed amount.	67
• Mail order (available in-network only)	For a 31-day up to a 90-day supply: Two copays	67
Dental care: Dental Fund of $300 for Self Only or $600 for 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.	37
Vision care: In-network (only) preventive care benefits.	Nothing	33
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.	45
Special features: Flexible benefits option**,** Aetna InteliHealth, Aetna Navigator, Informed Health Line, and Services for the deaf and hearing-impaired	Contact Plan	70-71
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after $4,000/Self Only or $8,000/Self and Family enrollment per year. Out-of-network: Nothing after $5,000/Self Only 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.	26-27

Summary of benefits for the HDHP of the Aetna HealthFund Plan-2012

- **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.
- In 2012, for each month you are eligible for the Health Savings Account (HSA), Aetna will deposit $62.50 per month for Self Only enrollment or $125 per month for Self and Family enrollment to your HSA. For the HSA, you may use your HSA or pay out of pocket to satisfy your calendar year deductible: In-network: $1,500 for Self Only enrollment and $3,000 for Self & Family enrollment or Out-of-Network $2,500 for Self Only and $5,000 for Self and Family. Once your calendar year deductible is satisfied, Traditional medical coverage begins.
- For the Health Reimbursement Arrangement (HRA), your health charges are applied first to your HRA Fund of $750 for Self Only and $1,500 for Self and Family. Once your HRA is exhausted, and applied toward reducing your calendar year deductible, you must pay out-of-pocket to satisfy the remainder of your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

HDHP Benefits	You Pay	Page
In-network medical and dental preventive care	Nothing at a network provider	87-90
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	92
Services provided by a hospital:		
• Inpatient	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	110-111
• Outpatient	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	111
Emergency benefits:	In-network: 10% of our Plan allowance Out-of-network: 10% of our Plan allowance and any difference between our allowance and the billed amount.	113-114
Mental health and substance abuse treatment:	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	115-117
Prescription drugs: • After your deductible has been satisfied, your copayment will apply.		118

Summary of benefits continued on next page

HDHP 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; and $60 per nonformulary (generic or brand name) Out-of-network (retail pharmacy only): 30% plus the difference between our Plan allowance and the billed amount.	119
• Mail order (available in-network only)	For a 31-day up to a 90-day supply: Two copays	119
Dental care:	No benefit other than in-network dental preventive care.	89-90
Vision care: In-network (only) preventive care benefits. $100 reimbursement for eyeglasses or contact lenses every 24 months.	Nothing	88-89
Special features: Flexible benefits option, Aetna InteliHealth, Aetna Navigator, Informed Health Line, and Services for the deaf and hearing-impaired	Contact Plan	123-124
Protection against catastrophic costs (out-of-pocket maximum)**:**	In-network: Nothing after $4,000/Self Only or $8,000/Self and Family enrollment per year. Out-of-network: Nothing after $5,000/Self Only 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.	26-27

2012 Rate Information for the Aetna HealthFund Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:
Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits.*

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
CDHP Option Self Only	221	$185.75	$72.02	$402.46	$156.04	$51.39	$48.81
CDHP Option Self and Family	222	$414.35	$171.03	$897.76	$370.56	$124.99	$119.23
HDHP Option Self Only	224	$130.32	$43.44	$282.36	$94.12	$28.67	$26.93
HDHP Option Self and Family	225	$285.41	$95.14	$618.40	$206.13	$62.79	$58.99