Aetna Health of Utah Inc. dba Altius Health Plan

www.aetnafeds.com/altius

800-537-9384

ALTIUS
An Aetna Plan

2018

A Health Maintenance Organization (High and Standard) options and a high deductible health plan (HDHP) option.

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This Plan is accredited. See page 13.

IMPORTANT
- Rates: Back Cover
- Changes for 2018: Page 20
- Summary of benefits: Page 158

Serving: Utah, Idaho and Wyoming

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 18 for requirements.

Enrollment codes for this Plan:

9K1 High Option - Self Only
9K3 High Option - Self Plus One
9K2 High Option - Self and Family

DK4 Standard Option - Self Only
DK6 Standard Option - Self Plus One
DK5 Standard Option - Self and Family

9K4 HDHP Option - Self Only
9K6 HDHP Option - Self Plus One
9K5 HDHP Option - Self and Family

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-564

Important Notice from Altius Health Plans About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 (TTY: 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 800-MEDICARE (800-633-4227), (TTY: 877-486-2048).

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Introduction

This brochure describes the benefits of Aetna Health of Utah Inc. dba Altius Health Plan under our contract (CS 2839) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 800-537-9384 or through our website: www.aetnafeds.com/altius. The address for the Plan's administrative offices is:

Aetna/Altius
Federal Plans
PO Box 550
Blue Bell, PA 19422-0550

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. If you are enrolled in Self Plus One coverage, you and one eligible family member that you designated when you enrolled are entitled to these benefits. You do not have a right to benefits that were available before January 1, 2018, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2018, and changes are summarized on page 20. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

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

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 Altius Health Plans.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

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

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800-537-9384 and explain the situation.
  - If we do not resolve the issue:

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

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

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

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

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- 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 services 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.

Discrimination is Against the Law

Aetna complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the Affordable Care Act. Pursuant to Section 1557, Aetna does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine 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.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic 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 or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:

- "Exactly what will you be doing?"

- "About how long will it take?"

- "What will happen after surgery?"

- "How can I expect to feel during recovery?"

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission’s Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. 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.bemedwise.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.

Preventable Healthcare Acquired Conditions (“Never Events”)

When you enter the hospital for treatment of one medical problem, you don’t expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct Never Events, if you us Altius Health Plans preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard (MVS)**

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

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

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

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

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

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

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

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

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

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

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

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

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

If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

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

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

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

- **Children's Equity Act**

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

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2018 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 2017 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 assistance with enrolling in 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 additional information about your coverage choices. You can also visit OPM's website at: www.opm.gov/healthcare-insurance/healthcare/plan-information/.

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

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

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

- **Finding replacement coverage** — If you leave Federal or Tribal service, your employing office will notify you of your right to convert**.** You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-537-9384 or visit our website at www.aetnafeds.com.

- **Health Insurance Marketplace**

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

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory. You have a choice of enrollment in a High Option, a Standard Option, or a High Deductible Health Plan (HDHP) Option.

OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. Aetna holds the following accreditations: National Committee for Quality Assurance ***and/or*** the local plans and vendors that support Aetna hold accreditation from the National Committee for Quality Assurance. To learn more about this plan's accreditation(s), please visit the following website:

- National Committee for Quality Assurance (www.ncqa.org)

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

General features of our High and Standard Options

- There is no deductible for our High and Standard Option plans.
- Most services provided by physicians and other health care professionals, including physician services that are provided while you are in a hospital, may be subject to a copayment or coinsurance.
- Comprehensive dental coverage is included in our High Option.
- The Standard Option does not include dental coverage (except for dental services that are necessary as a result of an accidental injury to sound, natural teeth).

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed:

- High Option: $4,500 for Self Only or $6,850 for Self Plus One or Self and Family coverage.
- Standard Option: $5,000 for Self Only or$6,850 for Self Plus One or Self and Family coverage.
- The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies). We compensate contracted providers by either discount fee-for-service fee schedules or capitation agreements. **It is your responsibility to verify that the provider you use is a Plan provider. Except for emergency and out-of-area urgent care, we will not pay for care or services from non-Plan providers or facilities unless it has been authorized by us. If you use a non-Plan provider or facility without authorization from us, you may be responsible for all charges.**

You do not have to select a Primary Care Physician (PCP), you may self-refer to Plan specialists. However, we recommend that you select a PCP to coordinate all of your medical care. A PCP should practice one of the following disciplines: General Practice, Family Medicine, Internal Medicine, Obstetrics/Gynecology (OB/GYN), or Pediatrics. **You are responsible for making sure that a provider is a Plan provider.** Should you have any questions, please contact out Customer Service Department at 800-537-9384, or visit our website at www.aetnafeds.com.

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

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

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

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 coverage), not enrolled in Medicare, not received VA (except for service connected disability), or Indian Health Services (IHS) benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), 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 the 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 a 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 HDHP 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. 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)

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.

Catastrophic protection

Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed $5,000 for Self Only enrollment, and $6,850 for a Self Plus One or Self and Family enrollment.

The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%.

Health education resources and accounts management tools

Connect to www.aetnafeds.com for access to 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 or HSA account balance and deductible balance or the status of a claim.

Navigator gives you direct access to:

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

For more information about these and other available tools and resources, please see HDHP Section 5(i).

Your rights and responsibilities

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. OPM's FEHB website (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.

- Altius Health Plan is a licensed Health Maintenance Organization in Utah, Idaho and Wyoming.
- Altius Health Plan has been in existence for more than 30 years.
- Altius Health Plan is a for-profit, Aetna Company.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, Aetna at www.aetnafeds.com. You can also contact us to request that we mail a copy to you.

If you want more information about us, call 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.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our Aetna website at www.aetnafeds.com to obtain a Notice of our Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

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 prescriptions drug utilization) to any of our 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 Altius.

Direct Access Ob/Gyn Program

This program allows female members to visit any participating gynecologist for a routine well-woman exam, including a Pap smear, one visit per calendar year. The program also allows female members to visit any participating gynecologist for gynecologic problems. Gynecologists may also refer a woman directly to other participating providers for specialized covered gynecologic services. All health plan preauthorization and coordination requirements continue to apply. If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG), an Integrated Delivery System (IDS) or a similar organization, your care must be coordinated through the IPA, the PMG, the IDS, or similar organization and the organization may have different referral policies.

Mental Health/Substance Misuse

Behavioral health services (e.g. treatment or care for mental disease or illness, alcohol abuse and/or substance misuse) are managed by Aetna Behavioral Health. We also make initial coverage determinations and coordinate referrals, if required; any behavioral health care referrals will generally be made to providers affiliated with the organization, unless your needs for covered services extend beyond the capability of these providers. As with other coverage determinations, you may appeal behavioral health care coverage decisions in accordance with the terms of your health plan.

Ongoing Reviews

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

Authorization

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

Patient Management

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

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

Precertification

Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or you. It also allows Altius 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 Altius 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.

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 Altius Health 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.
- Change your primary care physician or office.
- Obtain information about how to file a grievance or an appeal

Privacy Notice

Altius 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 HIPAA Member Rights Team, Aetna Inc., 151 Farmington Avenue, AN33, Hartford, CT 06156. You can also visit us at www.aetnafeds.com. You can link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link.

Service Area

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

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

Portions of Emery and Grand as defined by the following zip codes:

Emery - 84513, 84516, 84518, 84521, 84522, 84523, 84528, 84537

Grand - 84515, 84532

Idaho - The counties of Ada, Adams, Bannock, Bear Lake, Bingham, Blaine, Boise, Bonneville, Camas, Canyon, Caribou, Cassia, Clark, Custer, Elmore, Franklin, Fremont, Gem, Gooding, Jefferson, Jerome, Lincoln, Madison, Minidoka, Oneida, Owyhee, Payette, Power, Teton, Twin Falls, Valley and Washington.

Wyoming - The counties of Lincoln, Sweetwater, and Uinta

You must receive your care from providers who contract with us. If you receive care outside our service area, we will pay only for urgent or emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), they will be able to access full HMO benefits if they reside in any Aetna HMO service area by selecting a PCP in that service area. If not, you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. Changes for 2018

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.

Changes to High Option only

- Your share of the non-Postal premium will increase for Self Only, and increase for Self Plus One, and increase for Self and Family. (See page 162)
- **Home health infusion therapy –** The Plan will increase the member cost sharing to $35 per visit. (See page 45)
- **Diagnostic Tests** – The Plan will change the cost sharing for major diagnostic labs and radiology tests to a $200 copayment. (See page 34)
- **Outpatient Hospital and Surgery -** The Plan changed the cost share to $450 per visit. (See page 59)
- **Hospice** – The Plan will change the member cost sharing to a $5 copay. (See page 60)

Changes to the Standard Option only

- Your share of the non-Postal premium will increase for Self Only, and increase for Self Plus One, and increase for Self and Family. (See page 162)
- **Home health infusion therapy –** The Plan will increase the member cost sharing $40 per visit. (See page 45)
- **Diagnostic Tests** – The Plan will change the cost sharing for major diagnostic labs and radiology tests to a $250 copayment. (See page 34)
- **Outpatient Hospital and Surgery -** The Plan changed the cost share to $650 per visit. (See page 59)
- **Hospice** – The Plan will change the member cost sharing to $15 copay. (See page 60)

Changes to the High Deductible Health Plan only

- Your share of the non-Postal premium will increase for Self Only, and increase for Self Plus One, and increase for Self and Family. (See page 162)
- **Home health care** – The Plan will change the member cost sharing to $20 per visit after deductible. (See page 102)
- **Home health infusion therapy –** The Plan will increase the member cost sharing to $30 per visit after deductible. (See page 102)
- **Diagnostic Tests** – The Plan will change the cost sharing for major diagnostic labs and radiology tests to a $175 copayment after deductible. (See page 95)
- **Outpatient Hospital and Surgery -** The Plan changed the cost share to $500 per visit after deductible. (See page 115)
- **Hospice** – The Plan will change the member cost sharing to $10 copay after deductible. (See page 116)

Changes to the High Option, Standard Option and High Deductible Health Plan (HDHP) Option

- **Services that require plan approval (other services)** - The Plan updated its list of services that require plan approval now include: electric and motorized wheelchairs and scooters, home health care related services, referral or use of nonparticipating physician or provider for non-emergent services, video electroencephalographic (EEG) and Transthoracic echocardiogram. (See page 24)

- **Preventive care** - The Plan will now cover preventive mammograms for women age 65 and older once per calendar year. (See pages 35 and 90)
- **Telehealth services–** The Plan will now offer dermatological visits under the Teladoc telemedicine benefit. Specialist cost sharing applies. Teladoc will now provide services to member's located in Missouri and Arkansas.(See pages 33 and 94) The Plan will now cover behavioral health telemedicine consultations. (See pages 65 and 121)
- **Home health care –** The Plan will allow one (1) visit (up to 4 hours or less) per day up to 60 visits per member per calendar year. (See pages 45 and 102)
- **Prescription drugs –** The Plan will provide coverage for Statins as a preventive medication in accordance with U.S. Preventive Services Task Force guidance for $0 member cost sharing. (See pages 72 and 128)
- **Prescription drugs** - The Plan will now offer the Value formulary. Please refer to Aetna's website at www.aetnafeds.com/pharmacy for changes that may affect your current prescription. (See pages 68 and 124)
- **Service area expansions** - The Plan expanded its service area in the states below:
  - Idaho – Blaine, Boise, Camas, Cassia, Clark, Custer, Fremont, Gooding, Jerome, Lincoln, Minidoka, Owyhee, Teton, Twin Falls and Valley counties
  - Wyoming – Lincoln and Sweetwater counties

Section 3. How you get care

Open Access HMO

This Open Access Plan is available to our members in those FEHB Program service areas identified starting on page 18. You can go directly to any network specialist for covered services without a referral from your primary care physician. Whether your covered services are provided by your selected primary care physician (for your PCP copay) or by any other participating provider in the network (for the specialist copay), you will be responsible for payment which may be in the form of a copay (flat dollar amount) or coinsurance (a percentage of covered expenses). While not required, it is highly recommended that you still select a PCP and notify Member Services of your selection (800-537-9384). **If you go directly to a specialist, you are responsible for verifying that the specialist is participating in our Plan. If your participating specialist refers you to another provider, you are responsible for verifying that the other specialist is participating in our Plan.**

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan 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 800-537-9384 or write to us at Aetna, P.O. Box 14079, Lexington, KY 40512-4079. You may also request replacement cards through our Navigator website at www.aetnafeds.com.

Where you get covered care

You must receive care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance based on your benefit plan selection. This plan is Open Access which means you may receive covered services from any participating provider without a required referral from your primary care physician. Some services may require prior approval from the Plan.

- **Plan providers**

Plan 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 Plan providers according to national standards.

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. You and each family member are encouraged to choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You must select a Plan provider who is located in your service area as defined by your enrollment code.

- **Primary care**

Your primary care physician can be a General Practitioner, Family Practitioner, Internist, or Pediatrician. Your primary care physician will provide most of your health care.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us or visit our website and we will help you select a new one.

- **Specialty care**

Your primary care physician may refer you to a specialist for needed care or you may go directly to a specialist without a referral. However, if you need laboratory, radiological and physical therapy services, your primary care physician must refer you to certain plan providers.

Here are some other things you should know about specialty care:

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
- terminate our contract with your specialist for other than cause;
- 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 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 until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan 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.

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 Customer Service Department immediately at 800-537-9384. 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 cases, 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 primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under Other services.

You must get prior approval for certain services. Failure to do so will result in services not being covered.

- **Inpatient hospital admission**

  Precertification or prior authorization 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**

  Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

  - Inpatient confinements (except hospice) - For example, surgical and nonsurgical stays; stays in a skilled nursing facility or rehabilitation facility; and maternity and newborn stays that exceed the standard length of stay (LOS)
  - Observation stays more than 24 hours
  - Ambulance - Precertification required for transportation by fixed-wing aircraft (plane)
  - Autologous chondrocyte implantation, Carticel
  - Certain mental health services, inpatient admissions, Residential treatment center (RTC) admissions, Partial hospitalization programs (PHPs), Intensive outpatient programs (IOPs), Psychological testing, Neuropsychological testing, Outpatient detoxification, Transcranial magnetic stimulation (TMS) and Applied Behavior Analysis (ABA);
  - Cochlear device and/or implantation
  - Covered transplant surgery
  - Dialysis visits -When request is initiated by a participating provider, and dialysis to be performed at a nonparticipating facility
  - Dorsal column (lumbar) neurostimulators: trial or implantation
  - Electric or motorized wheelchairs and scooters
  - Gastrointestinal (GI) tract imaging through capsule endoscopy
  - Gender reassignment surgery
  - Hip surgery to repair impingement syndrome
  - Home health care related services
  - Hyperbaric oxygen therapy
  - In-network infertility services
  - Lower limb prosthetics, such as: Microprocessor controlled lower limb prosthetics
  - Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider
  - Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)
  - Osseointegrated implant
  - Osteochondral allograft/knee
  - Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids
  - Proton beam radiotherapy
  - Reconstructive or other procedures that maybe considered cosmetic, such as:
    - Blepharoplasty/canthoplasty
    - Breast reconstruction/breast enlargement

- Breast reduction/mammoplasty
- Cervicoplasty
- Excision of excessive skin due to weight loss
- Gastroplasty/gastric bypass
- Lipectomy or excess fat removal
- Surgery for varicose veins, except stab phlebectomy

- Referral or use of nonparticipating physician or provider for non-emergent services, unless the member understands and consents to the use of a nonparticipating provider under their out-of-network benefits when available in their plan
- Spinal procedures, such as:
  - Artificial intervertebral disc surgery
  - Cervical, lumbar and thoracic laminectomy/laminotomy procedures
  - Spinal fusion surgery
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices
- Video Electroencephalographic (EEG)
- Drugs and medical injectables (including but not limited to blood clotting factors, botulinum toxin, alpha-1-proteinase inhibitor, palivizumab (Synagis), erythropoietin therapy, intravenous immunoglobulin, growth hormone, blood clotting factors and interferons when used for hepatitis C)*
- Special Programs(including but not limited to BRCA genetic testing, Cardiac rhythm implantable devices, Hip and knee arthroplasties, National Medical Excellence Program®, Outpatient physical therapy (PT) and occupational therapy (OT) precertification, Pain management, Polysomnography (attended sleep studies), Radiation oncology, Radiology imaging (such as sleep studies, CT scans, MRIs, MRAs, nuclear stress tests), Transthoracic Echocardiogram*

*For a complete list refer to www.aetna.com/health-care-professionals/precertification/precertification-lists.html or the Specialty medications Precertification list.

Members must call 800-537-9384 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 800-537-9384 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- **Non-urgent care claims**

For non-urgent care claims, we will 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 let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required 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.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-537-9384. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-537-9384. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect. If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

Emergency inpatient admission

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

Maternity care

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than a total of three (3) days or less for a vaginal delivery or a total of five (5) days or less for a cesarean, 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.

Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

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.

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

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

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.
   You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

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

To reconsider an urgent care claim

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

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

To file an appeal with OPM

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

Section 4. Your costs for covered services

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

Cost-sharing

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

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

Example: When you see a primary care physician, you pay a copayment of $20 per office visit; and when you see a specialist, you pay a copayment of $35 per office visit.

High Deductible Health Plan Example: When you see a primary care physician, you pay a copayment of $20 per office visit (after your deductible has been met). When you see a specialist, you pay a copayment of $30 per office visit (after your deductible has been met).

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible.

- **High Option:** This Plan has no deductible
- **Standard Option:** This Plan has no deductible
- **High Deductible Health Plan:** The calendar year deductible is $1,300 for individual coverage (Self Only enrollment). Under a Self Plus One and Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for all family members reach $2,600. The entire family deductible must be satisfied before benefits are payable for any individual family member.

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

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

Coinsurance

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

Example: You pay 50% of our allowance for infertility services and durable medical equipment. (With the High Deductible Health Plan, this coinsurance applies after your deductible has been met.)

Differences between our Plan allowance and the bill

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: The total dollar amount allowed by the Plan for Covered Services, including the amounts payable by the Plan and payable by you.

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.

Your catastrophic protection out-of-pocket maximum

High Option

After your copayments and/or coinsurance total $4,500 for Self Only or $6,850 per Self Plus One, or $6,850 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services for the remainder of the calendar year. The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%. However, copayments and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Dental services

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the Plan's calculation of your out-of-pocket maximum is reflected accurately.

Standard Option

After your copayments and/or coinsurance total $5,000 for Self Only or $6,850 per Self Plus One or $6,850 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services for the remainder of the calendar year. The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%.

Be sure to keep accurate records and receipts of your copayments and coinsurance to ensure the Plan's calculation of your out-of-pocket maximum is reflected accurately.

High Deductible Health Plan

After your deductibles, copayments, and/or coinsurance total $5,000 for Self Only or $6,850 per Self Plus One or $6,850 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services for the remainder of the calendar year. The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%.

Be sure to keep accurate records and receipts of your copayments, applicable deductible and coinsurance to ensure the Plan's calculation of your out-of-pocket maximum is reflected accurately. If you have a question about when the out-of-pocket maximum is reached, please call our Customer Service Department at 800-537-9384.

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 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. High and Standard Option Benefits

See page 20 for how our benefits changed this year and pages 158-159 for a benefits summary.

This plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

Note: This benefits section 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 our benefits, contact us at 800-537-9384 or at our website at www.aetnafeds.com.

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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.
- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- 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.
- We encourage you to select a PCP by calling Member Services at 800-537-9384.
- **YOUR PHYSICIAN MUST OBTAIN PRIOR AUTHORIZATION FOR CERTAIN SERVICES, SUPPLIES, AND DRUGS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians • In a physician's office • Office medical evaluations, examinations, and consultations • Second surgical or medical opinion	$20 per office visit to a primary care physician $35 per office visit to a specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist
• In an urgent care center	$40 per visit	$40 per visit
• During a hospital stay • In a skilled nursing facility	Nothing See section 5(c) for facility charges.	15% of Plan Allowance See section 5(c) for facility charges.
Telehealth services	**High Option**	**Standard Option**
• Teladoc Please see www.aetnafeds.com for information on Teladoc service. Note: Members will receive a Teladoc welcome kit explaining the benefit. Note: Teladoc is not available for phone service in Idaho (video consults only). Note: For Behavioral Health telemedicine consults, please see Section 5(e).	$30 per consult	$40 per consult

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Minor diagnostic tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG • Sleep Studies	$30 copay	$40 copay
Major diagnostic labs and radiology tests, such as: • CT scans, MRIs, MRAs, and electron beam scans • PET and SPECT scans • Angiography, and other procedures that require vascular catheterization and/or the injection of medication, imaging contrast, or other substance • Any radiological procedure that must be performed in conjunction with a diagnostic surgical procedure (for example: ultrasonic guidance procedures) • Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes • Cytogenetic studies	$200 copay	$250 copay
Preventive care, adult	**High Option**	**Standard Option**
Routine physicals: • One (1) exam every calendar year Routine screenings, such as: • Routine urine test • Total Blood Cholesterol • Fasting lipid profile • Digital rectal examination (DRE) - one (1) annually for men aged 40 and older • Colorectal Cancer Screening, including: - Fecal occult blood test yearly starting at age 50 - Sigmoidoscopy screening - every five (5) years starting at age 50 - Colonoscopy screening - every ten (10) years starting at age 50 • Routine Prostate Specific Antigen (PSA) test - annually for men age 40 and older • Lung Cancer Screening – one (1) screening per year from age 55 years and over.	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Note: Physician consultation for colorectal screening visits prior to the procedure are not considered preventive. - Abdominal Aortic Aneurysm Screening - Ultrasonography, one (1) screening for men age 65 and older - Dietary and nutritional counseling for obesity - 26 visits annually Note: Some tests provided during a routine physical may not be considered preventive. Contact member services 800-537-9384 for information on whether a specific test is considered routine.	Nothing	Nothing
Well woman care based on current recommendations such as: • Routine well woman exam (one (1) visit per calendar year) • Cervical cancer screening (Pap smear) • Human Papillomavirus (HPV) testing • Chlamydia/Gonorrhea screening • Osteoporosis screening • Breast cancer screening • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence.	Nothing	Nothing
Routine mammogram – covered for women as follows: • From age 35 through 39, one (1) during this five (5) year period • From age 40 and older, one (1) every calendar year	Nothing	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule. • Tetanus, Diphtheria and Pertussis (Tdap) vaccine as a single dose for those 19 years of age and above • Tetanus-Diphtheria (Td) booster every ten (10) years • Influenza vaccine, annually • Varicella (chicken pox) for ages 19 to 49 years without evidence of immunity to varicella • Pneumococcal vaccine, age 65 and older • Human papillomavirus (HPV) vaccine for age 9 through age 27 • Herpes Zoster (Shingles) vaccine for age 50 and older	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Standard Option**
Note: Any procedure injection, diagnostic service, laboratory, or x-ray service done in connection with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx		
Not covered: • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters and medications for travel or work-related exposure.*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• We follow the CDC recommendations for preventive care and immunizations. For the list of preventive care and immunizations recommended by the CDC go to: www.cdc.gov/vaccines/schedules/index.html. • Screening examination of premature infants for Retinopathy of Prematurity- A retinal eye screening exam performed by ophthalmologist for infants with low birth weight (<1500g) or gestational age of 32 weeks or less and infants weighting between 1500g and 2000g or gestational age of more than 32 weeks with an unstable clinical course • Hearing loss screening of newborns provided by a participating hospital before discharge • Dietary and nutritional counseling for obesity - unlimited visits. Examinations limited to: • Examinations for amblyopia and strabismus – limited to one screening examination (ages 3 through 5) • Examinations done on the day of immunizations (ages 3 up to age 22)	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Standard Option**
Note: Some tests provided during a routine physical may not be considered preventive. Contact member services at 800-537-9384 for information on whether a specific test is considered routine. Well-child care charges for routine examinations, immunizations and care (up to age 26) • Seven (7) routine exams from birth to age 12 months • Three (3) routine exams from age 12 months to 24 months • Three (3) routine exams from age 24 months to 36 months • One (1) routine exam per year thereafter to age 26 Examinations such as: • Vision Screening through age 17 to determine the need for vision correction • Hearing exams through age 17 to determine the need for hearing correction • Routine examinations done on the day of immunizations (up to age 26)	Nothing	Nothing
Note: Any procedure injection, diagnostic service, laboratory, or x-ray service done in connection with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx.		
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	
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care includes the initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. • Screening for gestational diabetes for pregnant women after24 weeks • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see page 24for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary but you, your representative, your participating doctor, or your hospital must precertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. Please refer to Section 5(c). Services provided by a hospital or other facility, and ambulance services for inpatient maternity benefit coverage. Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	No copay for prenatal care or the first postpartum care visit $20 for PCP or $35 for specialist visit for postpartum care visits thereafter Note: If your PCP or specialist refers you to another specialist or facility for additional services, you pay the applicable copay for the service rendered.	No copay for prenatal care or the first postpartum care visit $20 for PCP or $40 for specialist visit for postpartum care visits thereafter Note: If your PCP or specialist refers you to another specialist or facility for additional services, you pay the applicable copay for the service rendered.
Breastfeeding support, supplies and counseling for each birth	Nothing	Nothing
Not covered: • *Home delivery*	*All charges*	*All charges*

Benefit Description	You pay	
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, such as: • Contraceptive counseling on an annual basis • Voluntary sterilization (See Surgical procedures Section 5 (b) • Surgically implanted contraceptives • Generic injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms Note: We cover injectable contraceptives under the medical benefit when supplied by and administered at the provider's office. Injectable contraceptives are covered at the prescription drug benefit when they are dispensed at the pharmacy. If a member must obtain the drug at the pharmacy and bring it to the provider's office to be administered, the member would be responsible for both the Rx and office visit copayments. We cover oral contraceptives under the Prescription drug benefit.	Nothing for women For men: $20 per PCP visit $35 for Specialist visit	Nothing for women For men: $20 per PCP visit $40 for Specialist visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Predictive Genetic testing and/or counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Infertility is a disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (six (6) months for women age 35 or older). • Testing for diagnosis and surgical treatment of the underlying medical cause of infertility.	50% of Plan Allowance	50% of Plan Allowance
Not covered: • *Any assisted reproductive technology (ART) procedure or services related to such procedures, including but not limited to in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection or* • *Artificial insemination (AI):* *– intravaginal insemination (IVI)* *– intracervical insemination (ICI)* *– intrauterine insemination (IUI) or* • *Any charges associated with care required to obtain ART services (e.g. office, hospital, ultrasounds, laboratory tests, etc); and any charges associated with obtaining sperm for any ART procedures.* • *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*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Standard Option**
• *Services associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g, office, hospital, ultrasounds, laboratory tests etc)* • *The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;* • *Reversal of voluntary, surgically-induced sterility sterilization surgery.* • *Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal* • *Injectable fertility drugs, including but not limited to menotropins, hCG, GnRH agonists, and IVIG* • *Infertility treatment when the FSH level is 19 mIU/ml or greater on day three (3) of menstrual cycle.* • *The purchase, freezing and storage of donor sperm and donor embryos.* • *Cost of home ovulation predictor kits or home pregnancy kits* • *Drugs related to the treatment of non-covered benefits* • *Infertility services that are not reasonably likely to result in success*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment	$20 per office visit to a primary care physician $35 per office visit to a specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist
• Allergy serum • Allergy injections	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• 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 51. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT)	$20 per office visit to a primary care physician $35 per office visit to a specialist $450 per visit in a surgical center, hospital, or other facility	$20 per office visit to a primary care physician $40 per office visit to a specialist $650 per visit in a surgical center, hospital, or other facility

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
• Intravenous (IV) Infusion Therapy in a doctor's office or facility (For IV infusion and antibiotic treatment at home, see Home Health Services.) Note: When provided in a physician's office or in an urgent care center, the services listed above do not include the cost of injectable, implantable and IV drugs; see below for the cost of the drugs. Note: We cover home IV infusion and antibiotic therapy administered by a home health agency under the *Home health services* benefit. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. *See Section 3 - Other services under You need prior Plan approval for certain services.* • Applied Behavior Analysis (ABA) – Children with autism spectrum disorder (see section 5(e) for benefits)	$20 per office visit to a primary care physician $35 per office visit to a specialist $450 per visit in a surgical center, hospital, or other facility	$20 per office visit to a primary care physician $40 per office visit to a specialist $650 per visit in a surgical center, hospital, or other facility
Physical, speech, and occupational habilitative and rehabilitative therapies	**High Option**	**Standard Option**
60 visits per person, per calendar year for physical or occupational therapy or a combination of both for the services of each of the following: • Qualified Physical therapists • Occupational therapists Note: We cover physical and occupational therapy under the *Home health services* benefit when provided by a home health agency as part of an authorized home treatment plan.	$35 per office visit	$40 per office visit
• Outpatient cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility for up to 12 weeks for Phase II and Phase III combined.	$35 per office visit	$40 per office visit
Not covered: • *Long-term habilitative and/or rehabilitative therapy* • *Therapy that we determine will not significantly improve your condition* • *Exercise programs*	*All charges*	*All charges*

Benefit Description	You pay	
Speech therapy	**High Option**	**Standard Option**
60 visits per person per calendar year	$35 per office visit	$40 per office visit
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M. D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$20 per office visit to a primary care physician $35 per office visit to a specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	For benefits for the devices, see Section 5(a) Orthopedic and prosthetic devices	For benefits for the devices, see Section 5(a) Orthopedic and prosthetic devices
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• Corrective eyeglasses and frames or contact lenses (hard or soft) for adults age 19 and older per 24-month period.	All charges over $100	All charges over $100
• Corrective eyeglasses and frames or contact lenses (hard or soft) for children through age 18 per 24-month period.* *Note: You must pay out-of-pocket for charges above the $100 allowance and submit a claim form for reimbursement of the 10%.	90% of charges after $100	90% of charges after $100
• One (1) routine eye exam (including refraction) every 12 month period Note: See *Preventive care, children* for eye exams for children	Nothing	Nothing
• Treatment of eye diseases and injury	$35 per Specialist office visit	$40 per Specialist office visit
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*	*All charges*

Benefit Description	You pay	
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$20 per office visit to a primary care physician $35 per office visit to a specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist
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 or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot Orthotics* • *Podiatric shoe inserts*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
Orthopedic devices such as braces and prosthetic devices such as artificial limbs and eyes. Limb and torso prosthetics must be preauthorized. • 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), penile implants, defibrillator, surgically implanted breast implant following mastectomy, and lenses following cataract removal. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome Note: Certain devices require precertification by you or your physician. Please see Section 3 for a list of services that require precertification. Note: Coverage includes repair and replacement when due to growth or normal wear and tear. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical and anesthesia services. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	50% of Plan Allowance	50% of Plan Allowance
• Hair prosthesis prescribed by a physician for hair loss resulting from radiation therapy, chemotherapy or certain other injuries, diseases, or treatment of a disease.	Nothing up to Plan lifetime maximum of $500	Nothing up to Plan lifetime maximum of $500
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Replacement of prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's physical condition* • *All charges over $500 for hair prosthesis*	*All charges*	*All charges*
Durable medical equipment (DME)	**High Option**	**Standard Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Contact Plan at 800-537-9384 for a complete list of covered DME. Some covered items include: • Oxygen systems and oxygen tanks • Dialysis equipment • Hospital beds (Clinitron and electric beds must be preauthorized) • Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Audible prescription reading devices • Insulin pumps	50% of Plan Allowance	50% of Plan Allowance
• Oxygen concentrators • Medically necessary accessories and supplies such as hoses, tubes, oxygen and ostomy supplies Note: You must get your DME from a participating DME provider. Some DME may require precertification by you or your physician.	Nothing	Nothing
Not covered: • *Durable medical equipment, corrective appliances, prostheses and artificial aids, including supplies and accessories, are excluded when primarily used for convenience, comfort, or in the absence of an illness or injury. Routine periodic servicing, such as cleaning and regulating is not covered.* • *Replacement of durable medical equipment, prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's condition.* • *Bathroom equipment such as bathtub seats, benches, rails and lifts.*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• *Home modifications such as stair glides, elevators and wheelchair ramps.* • *Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities.*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. 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 one (1) visit per day with each visit equal to a period of four (4) hours or less. The plan will allow up to 60 visits per member per calendar year. Your Plan Physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy Note: Skilled nursing under Home health services must be precertified by your Plan physician.	$35 per visit	$40 per visit
Intravenous (IV) Infusion Therapy and medications	$35 per visit	$40 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services provided by a family member or resident in the members 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*	*All charges*

Benefit Description	You pay	
Chiropractic	**High Option**	**Standard Option**
Coverage is limited to 20 visits per calendar year. Services include: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$20 per office visit to a primary care physician $35 per office visit to a specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist
Not covered: *Any services not listed above*	*All charges*	*All charges*
Alternative treatments	**High Option**	**Standard Option**
Biofeedback therapy for the treatment of certain conditions • Anesthesia • Pain relief	$20 per office visit to a primary care physician $35 per office visit to a specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist
Not covered: • *Acupuncture* • *Applied kinesiology* • *Aromatherapy* • *Craniosacral therapy* • *Hair analysis* • *Acupressure* • *Naturopathic or homeopathic services* • *Massage therapy* • *Hypnotherapy* • *Reflexology*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
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 • Depression • Cystic Fibrosis • Diabetes • Hepatitis • Inflammatory bowel disease • Kidney failure • Low back pain • Sickle cell disease	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High Option**	**Standard Option**
To request more information on our disease management programs, call 800-537-9384.	Nothing	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.	Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence.

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.
- Plan physicians must provide or arrange your care. It is your responsibility to verify that your physician has scheduled your surgery in a Plan facility. We will not pay for services provided by a non-Plan provider or facility without prior authorization.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- 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.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Removal of tumors and cysts • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Voluntary sterilization (e.g.,vasectomy) • Correction of congenital anomalies (see *Reconstructive surgery*) • Treatment of burns • Routine circumcision of a newborn • Insertion of internal prosthetic devices. See Section 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.	$20 per office visit to a primary care physician $35 per office visit to a specialist See section 5(c) for facility charges.	$20 per office visit to a primary care physician $40 per office visit to a specialist See section 5(c) for facility charges.

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Surgical treatment of morbid obesity (bariatric surgery) - a condition in which an individual has a body mass index (BMI) exceeding 40 or a BMI greater than 35 in conjunction with documented significant co-morbid conditions (such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea or refractory hypertension)** • Eligible members must be age 18 or over or have completed full growth • Members must complete a physician-supervised nutrition and exercise program within the past two years for a cumulative total of 6 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. All programs/regimens must be completed within six (6) months prior to surgery and the member must not have a net gain in weight during the program. • 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.	$20 per office visit to a primary care physician $35 per office visit to a specialist See section 5(c) for facility charges.	$20 per office visit to a primary care physician $40 per office visit to a specialist See section 5(c) for facility charges.
Voluntary sterilization for women (e.g., tubal ligation)	Nothing	Nothing
• Gender reassignment surgery* • The Plan will provide coverage for the following when the member meets Plan criteria: - Surgical removal of breasts for female-to-male patients - Surgical removal of uterus and ovaries in female-to-male and testes in male-to-female - Reconstruction of external genitalia** * Subject to medical necessity ** Note: Requires Precertification. See "Services requiring our prior approval" on page 24. You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 800-537-9384.	$20 per office visit to a primary care physician $35 per office visit to a specialist See section 5(c) for facility charges.	$20 per office visit to a primary care physician $40 per office visit to a specialist See section 5(c) for facility charges.
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*	*All charges*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
• *Routine treatment of conditions of the foot (see Foot care)*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • 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 lymphedemas - breast prostheses, and surgical bras (See *Orthopedic and prosthetic devices* in Section 5(a)) 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.	$20 per office visit to a primary care physician $35 per office visit to a specialist See section 5(c) for facility charges.	$20 per office visit to a primary care physician $40 per office visit to a specialist See section 5(c) for facility charges.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, that are medical in nature, such as: • Treatment of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Medically necessary surgical treatment of TMJ (must be preauthorized) • Excision of cysts and incision of abscesses when done as independent procedures; and	$20 per office visit to a primary care physician $35 per office visit to a specialist See section 5(c) for facility charges.	$20 per office visit to a primary care physician $40 per office visit to a specialist See section 5(c) for facility charges.

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Standard Option**
• Other surgical procedures that do not involve the teeth or their supporting structures • Removal of bony impacted wisdom teeth Note: When requesting oral and maxillofacial services, please check DocFind or call Member Services at 800-537-9384 for a participating oral and maxillofacial surgeon.	$20 per office visit to a primary care physician $35 per office visit to a specialist See section 5(c) for facility charges.	$20 per office visit to a primary care physician $40 per office visit to a specialist See section 5(c) for facility charges.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on page 24. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas; Pancreas/Kidney (simultaneous)	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.
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 - High-risk neuroblastoma - Multiple myeloma (de novo and treated)	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Recurrent germ cell tumors (including testicular cancer)	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.
Blood or marrow stem cell transplants 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 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. The Plan extends coverage for the diagnoses as indicated below. • Allogeneic (donor) transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reccurence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - 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	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer* - Ependymoblastoma - Epithelial ovarian cancer* - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors *Approved clinical trial necessary for coverage.	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.
Mini-transplants performed in a clinical trial setting (non-myeloblative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, Reduced Intensity Conditioning or RIC) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for: - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
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. 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 for 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.	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expense for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.		
Clinical trials must meet the following criteria: A. The member has a current diagnosis that will most likely cause death within one year or less despite therapy with currently accepted treatment; or the member has a diagnosis of cancer; AND B. *All* of the following criteria must be met: 1. Standard therapies have not been effective in treating the member or would not be medically appropriate; and 2. The risks and benefits of the experimental or investigational technology are reasonable compared to those associated with the member's medical condition and standard therapy based on at least two documents of medical and scientific evidence (as defined below); and 3. The experimental or investigational technology shows promise of being effective as demonstrated by the member's participation in a clinical trial satisfying ALL of the following criteria: a. The experimental or investigational drug, device, procedure, or treatment is under current review by the FDA and has an Investigational New Drug (IND) number; and b. The clinical trial has passed review by a panel of independent medical professionals (evidenced by Aetna's review of the written clinical trial protocols from the requesting institution) approved by Aetna who treat the type of disease involved and has also been approved by an Institutional Review Board (IRB) that will oversee the investigation; and	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
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.	$35 per specialist visit See section 5(c) for facility charges.	$40 per specialist visit See section 5(c) for facility charges.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered* • *Travel expenses, lodging, and meals*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing See section 5(c) for facility charges.	15% of Plan Allowance See section 5(c) for facility charges.
Professional services provided in – • Office	$20 per office visit to a primary care physician $35 per office visit to a specialist	$20 per office visit to a primary care physician $40 per office visit to a specialist

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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility. It is your responsibility to verify your physician has arranged for your care in a Plan facility. We will not pay for services provided by a non-Plan facility without prior authorization.
- 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.
- 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 PHYSICIAN MUST GET PRECERTIFICATION** FOR HOSPITAL STAYS. Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay	
Inpatient hospital services	**High Option**	**Standard Option**
Room and board, such as • Private Ward, 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.	$200 per day up to a maximum of $600 per admission	15% of Plan Allowance Inpatient maternity services - Nothing after a $200 per admission copay
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 • Anesthetics • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	$200 per day up to a maximum of $600 per admission	15% of Plan Allowance Inpatient maternity services - Nothing after a $200 per admission copay

Inpatient hospital services - continued on next page

Benefit Description	You pay	
Inpatient hospital services (cont.)	**High Option**	**Standard Option**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools, rest cures, domiciliary or convalescent cares* • *Whole blood and concentrated blood cells not replaced by the member* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• 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 • 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.	$450 per visit	$650 per visit
Services not associated with a medical procedure being done the same day such as: • Mammogram • Radiologic procedures* • Lab tests* *See below for exceptions	$35 per specialist visit	$40 per specialist visit
Complex diagnostic tests limited to: • CT scans, MRIs, MRAs, and electron beam scans • PET and SPECT scans • Angiography, and other procedures that require vascular catheterization and/or the injection of medication, imaging contrast, or other substance • Any radiological procedure that must be performed in conjunction with a diagnostic surgical procedure (for example: ultrasonic guidance procedures)	$200 copay	$250 copay

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center (cont.)	**High Option**	**Standard Option**
• Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes • Genetic testing—diagnostic* • Sleep studies *Note: These services need precertification. See "Services requiring prior approval" on page 24. *Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's medical condition.	$200 copay	$250 copay
Not covered: • *Personal comfort items* • *Whole blood and concentrated red blood cells not replaced by the member*	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Skilled nursing facility (SNF) / Extended care benefits: 30 days per member per calendar year • Professional services – physicians and general nursing care • Medical supplies and medications • Medical equipment ordinarily provided by a skilled nursing facility • Room and board	Nothing after $200 per admission copay	15% of Plan Allowance
Not covered: • *Custodial care, personal, comfort or convenience items*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
• Services for pain and symptom management • Short-term inpatient care and procedures necessary for pain control • Respite care may be provided only on an occasional basis and may not be provided longer than five days • Home visits made by a physician, nurse, home health aide, social worker or therapist with no limit on number of visits • General medical equipment and supplies related to the terminal illness	$5 copay	$15 copay
Not covered: • *Independent nursing* • *Homemaker services* • *Specialized, customized equipment*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**High Option**	**Standard Option**
The plan 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 To transport a member from home to hospital for medically necessary inpatients treatment when an ambulance is required to safely and adequately transport the member.	$100 copayment per trip	$100 copayment per trip
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 require prior approval from the Plan.*	*All charges*	*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.
- 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:

Emergencies within our service area:

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.

Whether you are in or out of an Altius HMO service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

- Call the local emergency hotline (e.g. 911) or go to the nearest emergency facility. For non-emergency services, care may be obtained from a walk-in clinic, an urgent care center or by calling Teladoc. If a delay would not be detrimental to your health, call your primary care physician. Notify your primary care physician as soon as possible after receiving treatment.
- After assessing and stabilizing your condition, the emergency facility should contact your primary care physician so he/she can assist the treating physician by supplying information about your medical history.
- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your primary care physician or Altius as soon as possible.

Emergencies outside our service area:

If you are traveling outside your Altius service area or if you are a student who is away at school, you are covered for emergency and urgently needed care. For non-emergency services, care may be obtained from a walk-in clinic, an urgent care center or by calling Teladoc. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Certain conditions, such as severe vomiting, or high fever, are considered "urgent care" outside your Altius service area and are covered in any of the above settings.

If, after reviewing information submitted to us by the provider that supplied care, the nature of the urgent or emergency problem does not qualify for coverage, it may be necessary to provide us with additional information. We will send you an Emergency Room Notification Report to complete, or a Member Services representative can take this information by telephone.

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency or urgent care at a doctor's office	$20 per PCP visit $35 per specialist visit	$20 per PCP visit $40 per specialist visit
• Emergency or urgent care at an urgent care center	$40 copayment per urgent care center visit	$40 copayment per urgent care center visit
• Emergency care as an outpatient at a hospital, (Emergency Room) including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$200 copayment per visit	$250 copayment per visit
Not covered: • *Elective care or non-emergency care in a hospital emergency room* • *Follow-up care in a hospital emergency room, unless we have given prior authorization*	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency or urgent care at a doctor's office	$20 per PCP visit $35 per specialist visit	$20 per PCP visit $40 per specialist visit
• Emergency or urgent care at an urgent care center	$40 copayment per urgent care center visit	$40 copayment per urgent care center visit
• Emergency care as an outpatient at a hospital, (Emergency Room) including doctors' services Note: We waive the ER copay if you are admitted to the hospital.	$200 copayment per visit	$250 copayment per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*	*All charges*
Telehealth services	**High Option**	**Standard Option**
• Teladoc Please see www.aetnafeds.com for information on Teladoc service. Note: Members will receive a Teladoc welcome kit explaining the benefit. Note: Teladoc is not available for phone service in Idaho.	$30 per consult	$40 per consult

Benefit Description	You pay	
Ambulance	**High Option**	**Standard Option**
The plan 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	$100 copayment per trip	$100 copayment per trip
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*	*All charges*

Section 5(e). Mental health and substance misuse disorder benefits

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. Please see Section 3 of this brochure for a list of services that require preauthorization.
- The Plan 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 behavioral health care services that are covered under your specific plan by calling Member Services at 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	
Professional services	**High Option**	**Standard Option**
We cover professional services by licensed professional mental health and substance misuse disorder treatment 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.	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: • Psychiatric office visits to Behavioral Health practitioner • SUD office visits to Behavioral Health practitioner • Routine psychiatric office visits to Behavioral Health practitioner • Behavioral therapy	$20 per office visit	$20 per office visit
• Telemedicine Behavioral Health consult	$20 per office visit	$20 per office visit
• Skilled behavioral health services provided in the home, but only when all of the following criteria are met: - You are home bound - Your physician order them	$20 per office visit	$20 per office visit

Professional services - continued on next page

Benefit Description	You Pay	
Professional services (cont.)	**High Option**	**Standard Option**
- The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications	$20 per office visit	$20 per office visit
Applied Behavior Analysis (ABA)	**High Option**	**Standard Option**
The Plan covers medically necessary Applied Behavior Analysis (ABA) therapy when provided by network behavioral health providers. These providers include: • Providers who are licensed or who possess a state-issued or state-sanctioned certification in ABA therapy. • Behavior analysts certified by the Behavior Analyst Certification Board (BACB). • Registered Behavior Technicians (RBTs) certified by the BACB or equivalent paraprofessionals who work under the supervision of a licensed provider or a certified behavior analyst. Note: Requires Precertification. See "Services requiring our prior approval" on page 24. You are responsible for ensuring that we are asked to precertify your care. You should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 800-537-9384.	$20 per visit	$20 per visit
Diagnostic	**High Option**	**Standard Option**
• Psychological and Neuropsychological testing provided and billed by a licensed mental health and substance misuse disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	$20 per office visit	$20 per office visit
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
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	$200 per day up to a maximum of $600 per admission	15% of Plan Allowance

Benefit Description	You Pay	
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility including other outpatient mental health treatment such as: • Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician • Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician • Outpatient detoxification • Ambulatory detoxification which is outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications • Treatment of withdrawal symptoms • Electro-convulsive therapy (ECT) • Mental health injectables • Substance abuse injectables • Transcranial magnetic stimulation (TMS) • Twenty-three (23) hour observation	$20 per office visit	$20 per office visit
Not Covered	**High Option**	**Standard Option**
• *Educational services for treatment of behavioral disorders* • *Services in half-way houses*	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- This is a five tier open formulary pharmacy plan, Value Formulary. A formulary is a list of generic and brand-name drugs that your health plan covers. Each drug is associated with a tier on the drug list. Tier-one is preferred generic drugs on our formulary list, Tier-two is preferred brand name drugs on our formulary list, Tier-three is non-preferred generic and brand drugs, Tier-four is preferred specialty drugs and Tier-five is non-preferred specialty. Each tier has a separate out-of-pocket cost.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorization for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- 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.
- Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Upon approval by the Plan, the prescription is covered for the current calendar year or a specified time period, whichever is less.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill non-emergency prescriptions at a participating Plan retail pharmacy or by mail order for 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, and for a 31-day up to a 90-day supply of medication for two (2) copays. In no event will the copay exceed the cost of the prescription drug. Please call Member Services at 800-537-9384 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.** In an emergency or urgent care situation, you may fill your covered prescription at any retail pharmacy. For retail pharmacy transactions, you must present your Member ID card at the point of sale for coverage. If you obtain an emergency prescription at a pharmacy that does not participate with the plan, you will need to pay the pharmacy the full price of the prescription and submit a claim for reimbursement subject to the terms and conditions of the plan.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the 2018Aetna Pharmacy Drug(Formulary) Guide. Certain drugs require your doctor to get precertification or step therapy from the Plan before they can be covered under the Plan. Your prescription drug plan includes drugs listed in the 2018Aetna Pharmacy Drug (Formulary) Guide. Prescription drugs listed on the formulary exclusions list are excluded unless a medical exception is approved by us. If it is medically necessary for you to use a prescription drug on the formulary exclusions list, you or your prescriber must request a medical exception. Visit our website at www.aetnafeds.com to review our 2018Aetna Pharmacy Drug (Formulary) Guide or call 800-537-9384.

- **Drugs not on the formulary.** Aetna has a Pharmacy and Therapeutics Committee, comprised of physicians, pharmacists and other clinicians that review drugs for inclusion in the formulary. They consider the drug's effectiveness, safety and cost in their evaluation. While most of the drugs on the non-formulary list are brand drugs, some generic drugs also may be on the non-formulary list. For example, this may happen when brand medications lose their patent and the FDA has granted a period of exclusivity to specific generic manufacturers. When this occurs, the price of the generic drug may not decrease as you might think most generic drugs do. This period of exclusivity usually ranges between 3-6 months. Once this time period expires, competition from other generic manufacturers will generally occur and this helps lower the price of the drug and this may lead Aetna to re-evaluate the generic for possible inclusion on the formulary. Aetna will place some of these generic drugs that are granted a period of exclusivity on our non-formulary list, which requires the highest copay level. **Remember, a generic equivalent will be dispensed, if available, unless your physician specifically requires a brand name and writes "Dispense as Written" (DAW) on the prescription, so discuss this with your doctor.**
- **Choose generics.** The Plan requires the use of generics if a generic drug is available. If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained from the Plan. Generics contain the same active ingredients in the same amounts as their brand name counterparts and have been approved by the FDA. By using generic drugs, you will see cost savings, without jeopardizing clinical outcome or compromising quality.
- **Precertification.** Your pharmacy benefits plan includes our precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by our Pharmacy Management Precertification Unit before they will be covered. Only your physician or pharmacist, in the case of an antibiotic or analgesic, can request prior authorization for a drug. Step-therapy is another type of precertification under which certain medications will be excluded from coverage unless you try one or more "prerequisite" drug(s) first, or unless a medical exception is obtained. The drugs requiring precertification or step-therapy are subject to change. Visit our website at www.aetnafeds.com for the most current information regarding the precertification and step-therapy lists. Ask your physician if the drugs being prescribed for you require precertification or step-therapy.
- **These are the dispensing limitations.** Prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy or by mail order may be dispensed for 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, and a 31-day up to a 90-day supply of medication for two copays. 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.

  In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filing of their medication(s) prior to departure, their pharmacist will need to contact the plan. 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.
- The Plan allows coverage of a medication refill when at least 80% of the previous prescription, according to the physician's prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a prescription refill to be covered 23 days after the last filling, thereby allowing a member to have an additional supply of their medication, in case of emergency.
- **When you do have to file a claim.** Send your itemized bill(s) to: Aetna, Pharmacy Management, P.O. Box 52444, Phoenix, AZ 85072-2444.

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

- A generic equivalent may be dispensed if it is available, and where allowed by law.

- **Specialty drugs.** Specialty drugs are medications that treat complex, chronic diseases which includes select oral, injectable and infused medications. 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 Formulary 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. If the provider supplies and administers the medication during an office visit, you will pay the applicable PCP or specialist office visit copay. If you obtain the prescribed medications directly from a participating specialty pharmacy such as Aetna Specialty Pharmacy, you will pay the applicable copay as outlined in Section 5(f) of this brochure.

  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 benefit please visit www.aetnafeds.com/pharmacy or contact us at 800-537-9384 for a copy. Note that the medications and categories covered are subject to change.

- To request a printed copy of the 2018Aetna Pharmacy Drug (Formulary) Guide, call 800-537-9384. The information in the 2018Aetna Pharmacy Drug (Formulary) Guide is subject to change. As brand name drugs lose their patents and new generics become available on the market, the brand name drug may be removed from the formulary. Under your benefit plan, this will result in a savings to you, as you pay a lower prescription copayment for generic formulary drugs. Please visit our website www.aetnafeds.com/pharmacy for current 2018Aetna Pharmacy Drug (Formulary) Guide information.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a licensed physician or dentist and obtained from a Plan pharmacy or through our mail order program: • Drugs approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as Not covered • Diabetic supplies limited to: - Lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips - Insulin - Disposable needles and syringes needed to inject covered prescribed medications • Prenatal vitamins (as covered under the plan's formulary) Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: $7 per covered generic formulary drug; $25 per covered brand name formulary drug; 40% per covered non-formulary (generic or brand name) drug up to $240 maximum Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $7 per covered generic formulary drug; $50 per covered brand name formulary drug; 40% per covered non-formulary (generic or brand name) drug up to $720 maximum	Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: $7 per covered generic formulary drug; $35 per covered brand name formulary drug; 50% per covered non-formulary (generic or brand name) drug up to $240 maximum Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $7 per covered generic formulary drug; $70 per covered brand name formulary drug; 50% per covered non-formulary (generic or brand name) drug up to $720 maximum
Women's contraceptive drugs and devices • Generic oral contraceptives on our formulary list	Nothing	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
• Generic emergency contraception, including OTC when filled with a prescription • Generic injectable contraceptives on our formulary list - five (5) vials per calendar year • Diaphragms - one (1) per calendar year • Brand name Intra Uterine Device • Generic patch contraception	Nothing	Nothing
• Brand name contraceptive drugs • Brand name injectable contraceptive drugs such as Depo Provera - five (5) vials per calendar year • Brand emergency contraception Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: $25 per covered brand name formulary drug; 40% per covered non-formulary (generic or brand name) drug up to $240 maximum Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $50 per covered brand name formulary drug; 40% per covered non-formulary (generic or brand name) drug up to $720 maximum	Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: $35 per covered brand name formulary drug; 50% per covered non-formulary (generic or brand name) drug up to $240 maximum Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $70 per covered brand name formulary drug; 50% per covered non-formulary (generic or brand name) drug up to $720 maximum
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 Formulary 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 70, Specialty Drugs for more information or visit: www.aetnafeds.com/pharmacy.	**Up to a 30-day supply per prescription or refill:** **Preferred:** 30% of Plan Allowance **Non-preferred (non-formulary):** 50% of Plan Allowance	**Up to a 30-day supply per prescription or refill:** **Preferred:** 30% of Plan Allowance **Non-preferred (non-formulary):** 50% of Plan Allowance
Limited benefits: • Drugs to treat erectile dysfunction are limited up to four (4) tablets per 30-day period. Contact the Plan at 800-537-9384 for dose limits. • Imitrex (limited to 48 kits per calendar year) Note: Mail order is not available.	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $7 per covered generic formulary drug; $25 per covered brand name formulary drug;	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $7 per covered generic formulary drug; $35 per covered brand name formulary drug;

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
	40% per covered non-formulary (generic or brand name) drug up to $240 maximum	50% per covered non-formulary (generic or brand name) drug up to $240 maximum
Preventive care medications	**High Option**	**Standard Option**
Preventive Care medications to promote better health as recommended by ACA. Drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. We will cover preventive medications in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations/guidance: • Aspirin • Folic acid supplements • Vitamin D supplements • Fluoride tablets • Statins Please refer to the Aetna formulary guide for a complete list of preventive drugs including coverage details and limitations: www.aetnafeds.com/pharmacy Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.	Nothing	Nothing
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug) unless required by law or covered by the plan.* • *Drugs obtained at a non-Plan pharmacy except when related to out-of-area emergency care*	*All charges*	*All charges*

Preventive care medications - continued on next page

Benefit Description	You pay	
Preventive care medications (cont.)	**High Option**	**Standard Option**
• *Vitamins, unless otherwise stated (including prescription vitamins), nutritional supplements, and any food item not listed as a covered benefit, including infant formula, medical foods and other nutritional items, even if it is the sole source of nutrition except for nutritional formulas for the treatment of phenylketonuria branched chain ketonuria, galactosemia and homocystinuria when administered under the direction of a Plan doctor (please see Durable Medical Equipment section on page 44).* • *Medical supplies such as dressings and antiseptics* • *Lost, stolen or damaged drugs* • *Drugs for cosmetic purposes* • *Fertility drugs* • *Drugs to enhance athletic performance* • *Drugs used for the purpose of weight reduction (i.e., appetite suppressants)* • *Prophylactic drugs including, but not limited to, anti-malarials for travel* • *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 with a prescription. (See page 47). OTC drugs will not be covered unless you have a prescription and that prescription is presented at the pharmacy and processed through our pharmacy claim system.*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- We have no calendar year deductible on the High Option.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- 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.
- **The Standard Option includes accidental dental injury benefits only. There are no other dental benefits for the Standard Option.**

Benefit Description	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$20 per office visit to a primary care physician $35 per office visit to a specialist See section 5(c) for facility charges.	$20 per office visit to a primary care physician $40 per office visit to a specialist See section 5(c) for facility charges.
Not covered: • *Implants*	*All charges*	*All charges*

Dental benefits

Note: This is not a complete list of covered dental services. To determine if other services are covered that are not listed, call Customer Service and provide the appropriate dental codes or service descriptions obtained from your dentist's office.

Dental benefits continued on next page

Dental Benefits	You Pay
Service	**High Option**
Oral evaluation	
- Periodic oral examination – one per member every six months - Limited oral evaluation – problem focused - Comprehensive oral evaluation	Nothing
- Comprehensive periodontal evaluation	Nothing
Radiographs - Intraoral full series x-rays – one per member every three years - Bitewing x-rays - Panoramic x-ray – one per member every three years	Nothing
Preventive	
• Prophylaxis and fluoride treatment (child) – one per member every six months • Prophylaxis (adult) – one per member every six months	Nothing
• Sealant – per tooth (through age 14)	Nothing
Emergency treatment - During office hours	
• Palliative treatment of dental pain	40%
Restorative Routine fillings – Amalgam or Resin-based composite for permanent or primary teeth	
Amalgam	
- 1 surface	40%
- 2 surfaces	40%
- 3 surfaces	40%
- 4 or more surfaces	40%
Resin-based composite – anterior	
- 1 surface	40%
- 2 surfaces	40%
- 3 surfaces	40%
- 4 or more surfaces	40%
Resin-based composite – posterior	
- 1 surface	40%
- 2 surfaces	40%
- 3 surfaces	40%
- 4 or more surfaces	40%

Service - continued on next page

Dental Benefits	You Pay
Service (cont.)	**High Option**
Periodontics	
Periodontal scaling and root planing – four or more teeth per quadrant	40%
Periodontal scaling and root planing – one to three teeth per quadrant	40%
Gingivectomy or gingivoplasty – per quadrant	40%
Gingivectomy or gingivoplasty – per tooth (to three teeth)	40%
Osseous surgery – four or more teeth per quadrant	60%
Osseous surgery – one to three teeth per quadrant	60%
Localized delivery of antimicrobial agents	40%
Periodontal maintenance	40%
Oral surgery	
Extractions (routine)	40%
Surgical removal of erupted tooth	40%
Impacted teeth – soft tissue	40%
Impacted teeth – partial bony	60%
Impacted teeth – full bony	60%
Endodontics	
Pulp cap	40%
Vital pulpotomy	40%
Root canal, single canal	40%
- two canals	40%
- three canals	60%
Crowns – Limited to six crowns per member per year	
Crown build up with pins	60%
Preformed post and build up	60%
Stainless steel crown	60%
Crown – porcelain fused to metal	60%
Crown – porcelain fused to precious metal	60%
Recement crown	40%
Removable dentures	
Complete denture (upper or lower)	60%
Partial denture (upper or lower)	60%
Denture adjustment	60%
Add tooth to existing partial denture	60%
Add clasp to existing partial denture	60%
Interim complete denture (upper or lower)	60%
Interim partial denture/stayplate (upper or lower)	60%
Replace missing or broken teeth, full or partial dentures, one involved tooth	60%

Service - continued on next page

Dental Benefits	You Pay
Service (cont.)	**High Option**
- Each additional tooth	60%
Reline denture (upper or lower) – chairside	60%
Reline denture (upper or lower) – lab	60%
Preventive appliances	
Space maintainer – unilateral	Nothing
Space maintainer – bilateral	Nothing
The following services are limited: • Replacement of prosthetic appliances less than five years old is covered only when good dental care dictates and such replacement is prescribed by a Plan dentist. • Single unit gold restorations and crowns are covered only when the tooth cannot be adequately restored with other restorative materials.	
Not covered: • *Implants* • *Bridges* • *Surgical grafting procedures* • *Treatment for developmental malformations such as enamel hypoplasia and fluorosis (brown and white stains on teeth)* • *Maxillary and mandibular malformations and anodontia* • *General anesthetic* • *Cosmetic or orthodontic treatment* • *Full mouth rehabilitation, periodontal splints, restoration of tooth structure lost from attrition and restoration for misalignment of the teeth* • *Dental treatment for temporomandibular (jaw) joint disorders and related diseases* • *Replacement of lost or stolen dentures, bridges or other dental appliances* • *Topical application of fluoride for adults*	*All charges*

Section 5. High Deductible Health Plan Benefits

See page 20 for how our benefits changed this year and page 160 for a benefits summary.

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Summary of benefits for the High Deductible Health Plan (HDHP) of Altius Health Plans - 2018 160

Section 5. High Deductible Health Plan 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* 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 800-537-9384 or on our website at www.aetnafeds.com.

Our HDHP option provides comprehensive coverage for high-cost medical events 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 HRA credit will be available on your effective date of enrollment.

With this Plan, 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. 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: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care**

  The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine prenatal and well-child care, child and adult immunizations, tobacco cessation programs, obesity weight loss programs, disease management and wellness programs. These services are covered at 100% if you use a network provider and the services are described in Section 5 *Preventive care. You do not have to meet the deductible before using these services.*

- **Traditional medical coverage**

  After you have paid the Plan's deductible, we pay benefits under traditional medical coverage described in Section 5. You typically pay $20 per office visit to a primary care physician, $35 per office visit to a specialist. The Plan typically pays 90% for home care and hospital care; you typically pay 10% of the Plan allowance.

  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
  - Dental benefits for services related to an accidental injury.

- **Savings**

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

Health Savings Accounts (HSAs)

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 (except for service connected disability) and/or Indian Health Services (IHS) benefits within the last three months or do not have other health insurance coverage other than another high deductible health plan. In 2018, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $54.16 per month for a Self Only enrollment or $108.33 per month for a Self Plus One enrollment or $108.33 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 $3,450 for an individual and $6,900 for a family. See maximum contribution information on page 85. 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 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:

- Your HSA is administered by Health Equity.
- Your contributions to the HSA are tax deductible. (State taxes apply in California, Alabama and New Jersey)
- 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. (New Hampshire and Tennessee do tax dividends and earnings on HSA's)
- 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).
- 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 an HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 11), 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.

In 2018, we will give you an HRA credit of $650 per year for a Self Only enrollment or $1,300 per year for a Self Plus One enrollment or $1,300 per year for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

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**

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

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

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

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	Health Equity is the non-bank custodian and preferred HSA administrator for this Plan. Health Equity has a relationship with Charles Schwab Bank to manage the investment options for members with an HSA. Members can contact Health Equity directly for assistance at 866-346-5800.	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 800-537-9384 or www.aetnafeds.com
Fees	Set-up fee is paid by the HDHP.	None.
Eligibility	You must: • Enroll in this HDHP • Not be in enrolled in another health plan that is not eligible to be coupled with an H.S.A. (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare Part A or Part B • Not be claimed as a dependent on someone else's tax return • Not receiving VA benefits or services unless they are due to a service related disability • Not have received Indian Health Services (IHS) benefits in the last three months • Complete and return all banking paperwork Eligibility for contributions is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
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. Premium pass through contributions will not be deposited to your H.S.A. until all banking paperwork is complete. Note: Annual premium pass through contributions will be forfeited if you do not return all banking paperwork by January 31st following the year for which contributions are made.	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.

	Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month.	
• **Self Only enrollment**	For 2018, a monthly premium pass through of $54.16 will be made by the HDHP directly into your HSA each month.	For 2018, your HRA annual credit is $650 (prorated for mid-year enrollment).
• **Self Plus One enrollment**	For 2018, a monthly premium pass through of $108.33 will be made by the HDHP directly into your HSA each month.	For 2018, your HRA annual credit is $1,300 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2018, a monthly premium pass through of $108.33 will be made by the HDHP directly into your HSA each month.	For 2018, your HRA annual credit is $1,300 (prorated for mid-year enrollment).
Contributions/ credits	The maximum that can be contributed to your HSA is an annual contribution of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,450 for individual self only coverage and $6,900 for a Self Plus One and Self and Family coverage. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You should take into account any IRA rollover contributions. You are eligible to contribute up to the IRS limit for 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 and 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). HSAs earn tax-free interest (does not affect your annual maximum contribution).	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.

	Catch-up contribution discussed on page 87.	
• **Self Only enrollment**	You may make an annual maximum contribution of $2,800.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make an annual maximum contribution of $5,600.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of $5,600.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit card • Website • Account Reimbursement form	For qualified medical expenses under your HDHP, you will be automatically reimbursed when claims are submitted through the HDHP. For expenses not covered by the HDHP, such as dental services, a reimbursement form will be sent to you upon your request.
Distributions/ withdrawals • **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 2018. 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 2017 and remain enrolled in this HDHP, your medical expenses incurred January 1, 2018 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 for a list of 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 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: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord 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, and • The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	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); and • The HDHP receives record of your enrollment and initially establishes your HRA account. • The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
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.	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.

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 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 data 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 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. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury website at www.treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx.

- **If you die**

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

- **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 800-829-3676, or visit the IRS website 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 will receive a periodic statement that shows the "premium pass through" withdrawals, and interest earned on your account. In addition, you will receive an Explanation of Payment statement when you withdraw money from your HSA.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount. However, funds will not be disbursed until your reimbursement totals at least $25.

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 an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

  Please review the chart on page 83 which details the differences between an HRA and an 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. 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. Preventive care

Important things you should keep in mind about these benefits:

- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- 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.
- Preventive care services listed in this section are not subject to the deductible. The Plan pays 100% for these preventive care services.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible*.
- 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 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 Funds.
- 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 PHYSICIAN MUST OBTAIN PRIOR AUTHORIZATION FOR CERTAIN SERVICES, SUPPLIES, AND DRUGS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay
Note: Deductible does not apply to preventive services.	
Preventive care, adult	
Routine physicals: • One (1) exam every calendar year Routine screenings, such as: • Routine urine test • Total Blood Cholesterol • Fasting lipid profile • Digital rectal examination (DRE) - one (1) annually for men aged 40 and older • Colorectal Cancer Screening, including: - Fecal occult blood test - yearly starting at age 50 - Sigmoidoscopy screening - every five (5) years starting at age 50 - Colonoscopy screening - every ten (10) years starting at age 50 • Routine Prostate Specific Antigen (PSA) test - annually for men age 40 and older • Lung Cancer Screening – one (1) screening per year from age 55 years and over. Note: Physician consultation for colorectal screening visits prior to the procedure are not considered preventive.	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
• Abdominal Aortic Aneurysm Screening—Ultrasonography, one (1) screening for men age 65 and older • Dietary and nutritional counseling for obesity—26 visits annually Note: Some tests provided during a routine physical may not be considered preventive. Contact member services 800-537-9384 for information on whether a specific test is considered routine.	Nothing
Well woman based on current recommendations such as: • Routine well woman exam (one (1) visit per calendar year) • Cervical cancer screening (Pap smear) • Human Papillomavirus (HPV) testing • Chlamydia/Gonorrhea screening • Osteoporosis screening • Breast cancer screening • Counseling for sexually transmitted infections • Counseling and screening for human immune-deficiency virus • Generic contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing
Routine mammogram — covered for women as follows: • From age 35 through 39, one (1) during this five (5) year period • From age 40 and older, one (1) every calendar year	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule. • Tetanus, Diphtheria and Pertussis (Tdap) vaccine as a single dose for those 19 years of age and above • Tetanus-Diphtheria (Td) booster every ten (10) years • Influenza vaccine, annually • Varicella (chicken pox) for ages 19 to 49 years without evidence of immunity to varicella • Pneumococcal vaccine, age 65 and older • Human papillomavirus (HPV) vaccine for age 9 through age 27 • Herpes Zoster (Shingles) vaccine for age 50 and older	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/	

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	
CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx	
Not covered • *Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Preventive care, children	
• We follow the CDC recommendations for preventive care and immunizations. Go to www.aetnafeds.com for the list of preventive care and immunizations. • Screening examination of premature infants for Retinopathy of Prematurity- A retinal eye screening exam performed by ophthalmologist for infants with low birth weight (<1500g) or gestational age of 32 weeks or less and infants weighing between 1500g and 2000g or gestational age of more than 32 weeks with an unstable clinical course • Hearing loss screening of newborns provided by a participating hospital before discharge • Dietary and nutritional counseling for obesity - unlimited visits. Examinations limited to: • Examinations for amblyopia and strabismus - limited to one screening examination (ages 3 through 5) • Examinations done on the day of immunizations (ages 3 up to age 22) Note: Some tests provided during a routine physical may not be considered preventive. Contact member services at 800-537-9384 for information on whether a specific test is considered routine. • Well-child care charges for routine examinations, immunizations and care (up to age 26) - Seven (7) routine exams from birth to age 12 months - Three (3) routine exams from age 12 months to 24 months - Three (3) routine exams from age 24 months to 36 months - One (1) routine exam per year thereafter to age 26 • Examinations such as: - Vision Screening through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
- Routine examinations done on the day of immunizations (up to age 26)	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to: brightfutures.aap.org/Pages/default.aspx	
Not covered • *Physical exams and immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel*	*All charges*

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Traditional medical coverage does not begin to pay until you have satisfied your deductible.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider. When applicable, you must use Plan facilities. You are responsible for verifying that your provider has arranged for your surgery or hospitalization in a Plan facility. We will not pay for services provided by a non-Plan provider or facility without our prior authorization.
- Preventive care services listed in the previous section are covered at 100% (see page 89) and are not subject to the calendar year deductible.
- The deductible is $1,300 per person $2,600 per Self Plus One enrollment, or $2,600 per Self and Family enrollment. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your coinsurance and copayments for covered expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $5,000 per person, $6,850 per Self Plus One enrollment or $6,850 per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. 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 non-covered expenses).
- 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 physician must obtain prior authorization for some services, supplies, and drugs. Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay After the calendar year deductible…
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from network providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $1,300 per person, $2,600 per Self Plus One enrollment or $2,600 per Self and Family enrollment.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance and copayments from your HSA or HRA, or you can pay for them out-of-pocket.

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.
- Plan physicians must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- The deductible is $1,300 for Self Only enrollment, $2,600 per Self Plus One enrollment, or $2,600 for a Self and Family enrollment each calendar year. The Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses.
- 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 PHYSICIAL MUST OBTAIN PRIOR AUTHORIZATION FOR SOME SERVICES, SUPPLIES, AND DRUGS.** Please refer to Section 3 for prior authorization information and to be sure which services require prior authorization.

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians • In a physician's office • Office medical evaluations, examinations, and consultations • Second surgical or medical opinion	$20 per office visit to a primary care physician $30 per office visit to a specialist
• In an urgent care center	$30 per visit
• During a hospital stay • In a skilled nursing facility	10% of Plan Allowance
Telehealth services	
• Teladoc Please see www.aetnafeds.com for information on Teladoc service. Note: Members will receive a Teladoc welcome kit explaining the benefit. Note: Teladoc is not available for phone service in Idaho (video consults only). Note: For Behavioral Health telemedicine consults, please see section 5(e).	$30 per consult

Benefit Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests	
Minor diagnostic tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	$30 copay
Major diagnostic labs and radiology tests, such as: • CT scans, MRIs, MRAs, and electron beam scans • PET and SPECT scans • Angiography, and other procedures that require vascular catheterization and/or the injection of medication, imaging contrast, or other substance • Any radiological procedure that must be performed in conjunction with a diagnostic surgical procedure (for example: ultrasonic guidance procedures) • Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes • Cytogenetic studies	$175 copay
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care - includes the initial and subsequent history, physical examinations, recording of weight, blood pressure, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. • Delivery • Postnatal care • Obstetrical care in an observation setting Note: Here are some things to keep in mind: • You do not need prior authorization for vaginal delivery; see page 24 for other circumstances, such as extended stays for your baby. • You may remain in the hospital up to 48 hours after a vaginal delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary, but you, your representative, your participating doctor, or your hospital must precertify the extended stay.	No copay for prenatal care or the first postpartum care visit 10% of Plan Allowance

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or a Self and Family enrollment. Note: Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • We cover ultrasounds and lab tests under the minor diagnostic services benefit. See *Lab, x-ray and other diagnostic tests* in this section. • We cover services related to complications of pregnancy the same as for any other illness. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	No copay for prenatal care or the first postpartum care visit 10% of Plan Allowance
Screening for gestational diabetes for pregnant women after24 weeks.	Nothing
Breastfeeding support, supplies and counseling for each birth	Nothing
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Home delivery*	*All charges*
Family planning	
A range of voluntary family planning services, such as: • Contraceptive counseling on an annual basis • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives • Intrauterine devices (IUDs)	Nothing for women For men: $20 per PCP visit $30 for Specialist visit
• Generic injectable contraceptive drugs 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 copayments. We cover oral contraceptives under the prescription drug benefit.	Nothing
Not covered: • *Reversal of voluntary surgical sterilization*	*All charges*

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible…
Family planning (cont.)	
• *Predictive genetic testing and/or genetic counseling.*	*All charges*
Infertility services	
Infertility is a disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (six (6) months for women age 35 or older). • Testing for diagnosis and surgical treatment of the underlying medical cause of infertility.	50% of Plan Allowance
Not covered: • *Any assisted reproductive technology (ART) procedure or services related to such procedures, including but not limited to in-vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection or* • *Artificial insemination (AI):* *– intravaginal insemination (IVI)* *– intracervical insemination (ICI)* *– intrauterine insemination (IUI) or* • *Any charges associated with care required to obtain ART services (e.g. office, hospital, ultrasounds, laboratory tests, etc); and any charges associated with obtaining sperm for any ART procedures.* • *Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services.* • *Services and supplies related to the above mentioned services, including sperm processing* • *Services associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g, office, hospital, ultrasounds, laboratory tests etc)* • *The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;* • *Reversal of voluntary, surgically-induced sterility sterilization surgery.* • *Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal* • *Injectable fertility drugs, including but not limited to menotropins, hCG, GnRH agonists, and IVIG* • *Infertility treatment when the FSH level is 19 mIU/ml or greater on day three (3) of menstrual cycle.* • *The purchase, freezing and storage of donor sperm and donor embryos.* • *Cost of home ovulation predictor kits or home pregnancy kits* • *Drugs related to the treatment of non-covered benefits*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	
• *Infertility services that are not reasonably likely to result in success*	*All charges*
Allergy care	
• Testing and treatment	$20 per office visit to a primary care physician $30 per office visit to a specialist
• Allergy serum • Allergy injections	Nothing
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 108. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) • Intravenous (IV) Infusion Therapy in a doctor's office or facility (For IV infusion and antibiotic treatment at home, see Home Health Services.) Note: When provided in a physician's office or in an urgent care center, the services listed above do not include the cost of injectable, implantable and IV drugs; see below for the cost of the drugs. Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that be determine are medically necessary. See *Section 3. How you get care - Other services.* Note: We cover home IV infusion and antibiotic therapy administered by a home health agency under the *Home health services* benefit. • Applied Behavior Analysis (ABA) - Children with autism spectrum disorder (see section 5(e) for benefits)	$20 per office visit to a primary care physician $30 per office visit to a specialist $500 per visit in a surgical center, hospital, or other facility

Benefit Description	You pay After the calendar year deductible…
Physical, speech, and occupational habilitative and rehabilitative therapies	
60 visits per person, per calendar year for physical or occupational therapy or a combination of both for the services of each of the following: • Qualified Physical therapists • Occupational therapists Note: We cover physical and occupational therapy under the *Home health services* benefit when provided by a home health agency as part of an authorized home treatment plan	$30 per office visit
• Outpatient cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility for up to 12 weeks for Phase II and Phase III combined	$30 per office visit
Not covered: • *Long-term habilitative and rehabilitative therapy* • *Therapy that we determine will not significantly improve your condition* • *Exercise programs*	*All charges*
Speech therapy	
60 visits per person per calendar year Note: We cover speech therapy under the *Home health services* benefit when provided by a home health agency as part of an authorized home treatment plan.	$30 per office visit
Not covered: • *Speech therapy for psychosocial and/or developmental delays, such as but not limited to, childhood stuttering*	*All charges*
Hearing services (testing, treatment, and supplies)	
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$20 per office visit to a primary care physician $30 per office visit to a specialist
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	For benefits for the devices, see Section 5(a) Orthopedic and prosthetic devices
Not covered: • *Hearing services that are not shown as covered*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Vision services (testing, treatment, and supplies)	
• Corrective eyeglasses and frames or contact lenses (hard or soft) for adults age 19 and older per 24-month period.	All charges over $100
• Corrective eyeglasses and frames or contact lenses (hard or soft) for children through age 18 per 24-month period.* *Note: You must pay for charges above the $100 allowance and submit a claim form for reimbursement of the 10%.	90% of charges after $100
• One routine eye exam (including refraction) every 12 month period Note: See *Preventive care, adults and children* for eye exams	Nothing
• Treatment of eye diseases and injury	$30 per office visit
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	$20 per office visit to a primary care physician $30 per office visit to a specialist
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 or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot Orthotics* • *Podiatric shoe inserts*	*All charges*
Orthopedic and prosthetic devices	
Orthopedic devices such as braces and prosthetic devices such as artificial limbs and eyes. Limb and torso prosthetics must be preauthorized. • 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), penile implants, defibrillator, surgically implanted breast implant following mastectomy, and lenses following cataract removal.	50% of Plan Allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome Note: Certain devices require precertification by you or your physician. Please see Section 3 for a list of services that require precertification. Note: Coverage includes repair and replacement when due to growth or normal wear and tear. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) *Surgical and anesthesia services.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) *Services provided by a hospital or other facility, and ambulance services.*	50% of Plan Allowance
• Hair prosthesis prescribed by a physician for hair loss resulting from radiation therapy, chemotherapy or certain other injuries, diseases, or treatment of a disease.	Nothing up to Plan lifetime maximum of $500
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Replacement of prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's physical condition* • *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 800-537-9384 for a complete list of covered DME. Some covered items include: • Oxygen systems and oxygen tanks • Dialysis equipment • Hospital beds (Clinitron and electric beds must be authorized) • Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Speech generating devices • Blood glucose monitors • Insulin pumps • Audible prescription reading devices	50% of Plan Allowance

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	
• Oxygen concentrators; and • Medically necessary accessories and supplies such as hoses, tubes, oxygen and ostomy supplies	10% of Plan Allowance
Note: You must get your DME from a participating DME provider. Some DME may require precertification by you or your physician.	
Not covered: • *Durable medical equipment, corrective appliances, prostheses and artificial aids, including supplies and accessories, are excluded when primarily used for convenience, comfort, or in the absence of an illness or injury. Routine periodic servicing, such as cleaning and regulating is not covered.* • *Replacement of durable medical equipment, prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's condition.* • Bathroom equipment such as bathtub seats, benches, rails and lifts • Home modifications such as stair glides, elevators and wheelchair ramps • Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. 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 one (1) visit per day with each visit equal to a period of four (4) hours or less. The plan will allow up to 60 visits per member per calendar year. Your Plan Physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy	$20 per visit
Intravenous (IV) Infusion Therapy and medications	$30 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication*	*All charges*

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Home health services (cont.)	
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services provided by a family member or resident in the members 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	
Coverage is limited to 20 visits per calendar year. Services include: • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$30 per office visit to a specialist
Not covered: *Any services not listed above*	*All charges*
Alternative treatments	
Biofeedback therapy for the treatment of certain conditions • Anesthesia • Pain Relief	$20 per office visit to a primary care physician $30 per office visit to a specialist See section 5(c) for facility charges.
Not covered: • *Acupuncture* • *Applied kinesiology* • *Aromatherapy* • *Craniosacral therapy* • *Hair analysis* • *Acupressure* • *Naturopathic or homeopathic services* • *Massage therapy* • *Hypnotherapy* • *Reflexology*	*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 • Depression • Cystic Fibrosis • Diabetes • Hepatits • Inflammatory bowel disease • Kidney failure • Low back pain • Sickle cell disease To request more information on our disease management programs, call 800-537-9384.	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.	Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence.

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.
- Plan physicians must provide or arrange your care. It is your responsibility to verify that your physician has scheduled your surgery in a Plan facility. We will not pay for services provided by a non-Plan provider or facility without our prior authorization.
- The deductible is $1,300 for Self Only enrollment, $2,600 per Self Plus One enrollment, and $2,600 for Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION** FOR SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

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 • Removal of tumors and cysts • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Voluntary sterilization for men (e.g., vasectomy) • Correction of congenital anomalies (see *Reconstructive surgery*) • Treatment of burns • Routine circumcision of a newborn • Insertion of internal prosthetic devices. See Section 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.	$20 per office visit to a primary care physician $30 per office visit to a specialist See section 5(c) for facility charges.
Voluntary sterilization for women (e.g., tubal ligation)	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
Surgical treatment of morbid obesity (bariatric surgery) - a condition in which an individual has a body mass index (BMI) exceeding 40 or a BMI greater than 35 in conjunction with documented significant co-morbid conditions (such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea or refractory hypertension).** • Eligible members must be age 18 or over or have completed full growth • Members must complete a physician-supervised nutrition and exercise program within the past two years for a cumulative total of 6 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. All programs/regimens must be completed within six (6) months prior to surgery and the member must not have a net gain in weight during the program. • 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.	$20 per office visit to a primary care physician $30 per office visit to a specialist See section 5(c) for facility charges.
• Gender reassignment surgery* • The Plan will provide coverage for the following when the member meets Plan criteria: - Surgical removal of breasts for female-to-male patients - Surgical removal of uterus and ovaries in female-to-male and testes in male-to-female - Reconstruction of external genitalia** * Subject to medical necessity ** Note: Requires Precertification. See "Services requiring our prior approval" on page 24. You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 800-537-9384.	$20 per office visit to a primary care physician $30 per office visit to a specialist See section 5(c) for facility charges.
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*

Benefit Description	You pay After the calendar year deductible…
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • 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 lymphedemas - breast prostheses and surgical bras (See *Orthopedic and prosthetic devices* in Section 5(a)) 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.	$20 per office visit to a primary care physician $30 per office visit to a specialist See section 5(c) for facility charges.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*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 • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Medically necessary surgical treatment of TMJ (must be preauthorized) • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • Removal of bony impacted wisdom teeth Note: When requesting oral and maxillofacial services, please check DocFind or call Member Services at 800-537-9384 for a participating oral and maxillofacial surgeon.	$20 per office visit to a primary care physician $30 per office visit to a specialist See section 5(c) for facility charges.

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on page 24. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-Pancreas • Liver • Lung: single/bilateral/lobar • Pancreas; Pancreas/Kidney (simultaneous)	$30 per specialist visit See section 5(c) for facility charges.
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 - High-risk neuroblastoma - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$30 per specialist visit See section 5(c) for facility charges.
Blood or marrow stem cell transplants 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 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. The Plan extends coverage for the diagnoses as indicated below.	$30 per specialist visit See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - 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 nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) - Amyloidosis - Breast Cancer* - Ependymoblastoma - Epithelial ovarian cancer* - Ewing's sarcoma - Multiple myeloma	$30 per specialist visit See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Medulloblastoma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors *Approved clinical trial necessary for coverage.	$30 per specialist visit See section 5(c) for facility charges.
Mini-transplants performed in a clinical trial setting (non-myeloblative, 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 nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (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 PHN, 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 reccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reccurrence (relapsed) - Amyloidosis - Neuroblastoma	$30 per specialist visit See section 5(c) for facility charges.
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.	$30 per specialist visit See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
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.	$30 per specialist visit See section 5(c) for facility charges.
• Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • Autologous Transplants for:	

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive 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 - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	$30 per specialist visit See section 5(c) for facility charges.
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. 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 for 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.	$30 per specialist visit See section 5(c) for facility charges.
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor screening tests and donor search expense for the actual solid organ donor or up to four 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	$30 per specialist visit See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
2. The risks and benefits of the experimental or investigational technology are reasonable compared to those associated with the member's medical condition and standard therapy based on at least two documents of medical and scientific evidence (as defined below); and 3. The experimental or investigational technology shows promise of being effective as demonstrated by the member's participation in a clinical trial satisfying ALL of the following criteria: a. The experimental or investigational drug, device, procedure, or treatment is under current review by the FDA and has an Investigational New Drug (IND) number; and b. The clinical trial has passed review by a panel of independent medical professionals (evidenced by Aetna's review of the written clinical trial protocols from the requesting institution) approved by Aetna who treat the type of disease involved and has also been approved by an Institutional Review Board (IRB) that will oversee the investigation; and c. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national cooperative body (e.g., Department of Defense, VA Affairs) and conforms to the rigorous independent oversight criteria as defined by the NCI for the performance of clinical trials; and d. The clinical trial is not a single institution or investigator study (NCI designated Cancer Centers are exempt from this requirement); and 4. The member must: a. Not be treated "off protocol," and b. Must actually be enrolled in the trial.	$30 per specialist visit See section 5(c) for facility charges.
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered* • *Travel expenses, lodging, and meals*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	10% of Plan Allowance
Professional services provided in – • Office	$20 per office visit to a primary care physician $30 per office visit to a specialist

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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The deductible is $1,300 for Self Only enrollment, $2,600 for Self Plus One enrollment and $2,600 for Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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 PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as • Private Ward, 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.	10% of Plan Allowance
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 • Anesthetics • Take-home items	10% of Plan Allowance

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	10% of Plan Allowance
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, long-term care facilities, and schools, rest cures, domiciliary or convalescent cares* • *Whole blood and concentrated blood cells not replaced by the member* • *Personal comfort items, such as telephone, television, barber services, 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 • Diagnostic laboratory tests and X-rays • 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.	$500 per visit
Services not associated with a medical procedure being done the same day such as: • Mammogram • Radiologic procedures* • Lab tests* *See below for exceptions	$30 per specialist visit
Complex diagnostic tests limited to: • CT scans, MRIs, MRAs, and electron beam scans • PET and SPECT scans • Angiography, and other procedures that require vascular catheterization and/or the injection of medication, imaging contrast, or other substance • Any radiological procedure that must be performed in conjunction with a diagnostic surgical procedure (for example: ultrasonic guidance procedures)	$175 copay

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Outpatient hospital or ambulatory surgical center (cont.)	
• Diagnostic nuclear medicine, including provision of radiopharmaceuticals for diagnostic purposes • Genetic testing—diagnostic* • Sleep studies *Note: These services need precertification. See "Services requiring prior approval" on page 24. *Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's medical condition.	$175 copay
Not covered: • *Personal comfort items* • *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 30 day per member per calendar year limit when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	10% of Plan Allowance
Not covered: • *Custodial care, personal, comfort or convenience items*	*All charges*
Hospice care	
• Services for pain and symptom management • Short-term inpatient care and procedures necessary for pain control • Respite care may be provided only on an occasional basis and may not be provided longer than five (5) days • Home visits made by a physician, nurse, home health aide, social worker or therapist with no limit on number of visits • General medical equipment and supplies related to the terminal illness	$10 copay
Not covered: • *Independent nursing* • *Homemaker services* • *Specialized, customized equipment*	*All charges*

Benefit Description	You Pay After the calendar year deductible...
Ambulance	
The plan 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 To transport a member from home to hospital for medically necessary inpatients treatment when an ambulance is required to safely and adequately transport the member	10% of Plan Allowance
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 require 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 $1,300 for Self Only enrollment, $2,600 per Self Plus One enrollment and $2,600 for Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses.
- 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:

- **Emergencies within our service area:**

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.

Whether you are in or out of an Altius HMO service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

- Call the local emergency hotline (e.g. 911) or go to the nearest emergency facility. For non-emergency services, care may be obtained from a walk-in clinic, an urgent care center or by calling Teladoc. If a delay would not be detrimental to your health, call your primary care physician. Notify your primary care physician as soon as possible after receiving treatment.
- After assessing and stabilizing your condition, the emergency facility should contact your primary care physician so he/she can assist the treating physician by supplying information about your medical history.
- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your primary care physician or Altius as soon as possible.
- **Emergencies outside our service area:**

If you are traveling outside your Altius service area or if you are a student who is away at school, you are covered for emergency and urgently needed care. For non-emergency services, care may be obtained from a walk-in clinic, an urgent care center or by calling Teladoc. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Certain conditions, such as severe vomiting, or high fever, are considered "urgent care" outside your Altius service area and are covered in any of the above settings.

If, after reviewing information submitted to us by the provider that supplied care, the nature of the urgent or emergency problem does not qualify for coverage, it may be necessary to provide us with additional information. We will send you an Emergency Room Notification Report to complete, or a Member Services representative can take this information by telephone.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	
• Emergency or urgent care at a doctor's office	$20 per PCP visit $30 per specialist visit
• Emergency or urgent care at an urgent care center	$30 copayment per urgent care center visit
• Emergency care as an outpatient at a hospital, (Emergency Room) including doctors' services Note: Inpatient facility benefits apply if you are admitted to the hospital; see *Inpatient hospital* in Section 5(c).	$200 copayment per visit
Not covered: • *Elective care or non-emergency care in a hospital emergency room* • *Follow-up care in a hospital emergency room, unless we have given prior authorization*	*All charges*
Emergency outside our service area	
• Emergency or urgent care at a doctor's office	$20 per PCP visit $30 per specialist visit
• Emergency or urgent care at an urgent care center	$30 copayment per urgent care center visit
• Emergency care as an outpatient at a hospital, (Emergency Room) including doctors' services Note: Inpatient facility benefits apply if you are admitted to the hospital; see *Inpatient hospital* in Section 5(c).	$200 copayment per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Telehealth services	
• Teladoc Please see www.aetnafeds.com for information on Teladoc service. Note: Members will receive a Teladoc welcome kit explaining the benefit. Note: Teladoc is not available for phone service in Idaho.	$30 per consult
Ambulance	
Altius 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	10% of Plan Allowance
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 misuse disorder benefits

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. Please see Section 3 of this brochure for a list of services that require preauthorization.
- The Plan can assist you in locating participating providers, 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 behavioral health care services that are covered under your specific plan by calling Member Services at 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 medically necessary treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Professional services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Psychiatric office visits to Behavioral Health practitioner • SUD office visits to Behavioral Health practitioner • Routine psychiatric office visits to Behavioral Health practitioner • Behavioral therapy	$20 per office visit
• Telemedicine Behavioral Health consult	$20 per office visit
• Skilled behavioral health services provided in the home, but only when all of the following criteria are met: - You are home bound - Your physician order them	$20 per office visit

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional services (cont.)	
- The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications	$20 per office visit
Applied Behavior Analysis (ABA)	
The plan covers medically necessary applied behavior analysis (ABA) therapy when provided by network behavioral health providers. These providers include: • Providers who are licensed or who possess a state-issued or state-sanctioned certification in ABA therapy. • Behavior analysts certified by the Behavior Analyst Certification Board (BACB). • Registered Behavior Technicians (RBTs) certified by the BACB or equivalent paraprofessionals who work under the supervision of a licensed provider or a certified behavior analyst. Note: Requires Precertification. See "Services requiring our prior approval" on page 24. You are responsible for ensuring that we are asked to precertify your care. You should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 800-537-9384.	$20 per visit
Diagnostic	
• Psychological and Neuropsychological testing provided and billed by a licensed mental health and substance misuse disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	$20 per office visit
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	10% of Plan Allowance

Benefit Description	You pay After the calendar year deductible…
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility including other outpatient mental health treatment such as: • Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician • Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician • Outpatient detoxification • Ambulatory detoxification which is outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications • Treatment of withdrawal symptoms • Electro-convulsive therapy (ECT) • Mental health injectables • Substance abuse injectables • Transcranial magnetic stimulation (TMS) • Twenty-three (23) hour observation	$20 per office visit
Not Covered	
• *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:

- This is a five tier open formulary pharmacy plan, Value Formulary. A formulary is a list of generic and brand-name drugs that your health plan covers. Each drug is associated with a tier on the drug list. Tier-one is preferred generic drugs on our formulary list, Tier-two is preferred brand name drugs on our formulary list, Tier-three is non-preferred generic and brand drugs, Tier-four is preferred specialty drugs and Tier-five is non-preferred specialty. Each tier has a separate out-of-pocket cost.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- The deductible is $1,300 for Self Only and $2,600 for Self Plus One and Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorization for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- 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.
- Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Upon approval by the Plan, the prescription is covered for the current calendar year or a specified time period, whichever is less.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill non-emergency prescriptions at a participating Plan retail pharmacy or by mail order for 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, and for a 31-day up to a 90-day supply of medication for two (2) copays. In no event will the copay exceed the cost of the prescription drug. Please call Member Services at 800-537-9384 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.** In an emergency or urgent care situation, you may fill your covered prescription at any retail pharmacy. For retail pharmacy transactions, you must present your Member ID card at the point of sale for coverage. If you obtain an emergency prescription at a pharmacy that does not participate with the plan, you will need to pay the pharmacy the full price of the prescription and submit a claim for reimbursement subject to the terms and conditions of the plan.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the 2018 Aetna Pharmacy Drug (Formulary) Guide. Certain drugs require your doctor to get precertification or step therapy from the Plan before they can be covered under the Plan. Your prescription drug plan includes drugs listed in the 2018 Aetna Pharmacy Drug (Formulary) Guide. Prescription drugs listed on the formulary exclusions list are excluded unless a medical exception is approved by us. If it is medically necessary for you to use a prescription drug on the formulary exclusions list, you or your prescriber must request a medical exception. Visit our website at www.aetnafeds.com to review our 2018 Aetna Pharmacy Drug (Formulary) Guide or call 800-537-9384.

- **Drugs not on the formulary.** Aetna has a Pharmacy and Therapeutics Committee, comprised of physicians, pharmacists and other clinicians that review drugs for inclusion in the formulary. They consider the drug's effectiveness, safety and cost in their evaluation. While most of the drugs on the non-formulary list are brand drugs, some generic drugs also may be on the non-formulary list. For example, this may happen when brand medications lose their patent and the FDA has granted a period of exclusivity to specific generic manufacturers. When this occurs, the price of the generic drug may not decrease as you might think most generic drugs do. This period of exclusivity usually ranges between 3-6 months. Once this time period expires, competition from other generic manufacturers will generally occur and this helps lower the price of the drug and this may lead Aetna to re-evaluate the generic for possible inclusion on the formulary. Aetna will place some of these generic drugs that are granted a period of exclusivity on our non-formulary list, which requires the highest copay level. **Remember, a generic equivalent will be dispensed, if available, unless your physician specifically requires a brand name and writes "Dispense as Written" (DAW) on the prescription, so discuss this with your doctor.**
- **Choose generics.** The Plan requires the use of generics if a generic drug is available. If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained from the Plan. Generics contain the same active ingredients in the same amounts as their brand name counterparts and have been approved by the FDA. By using generic drugs, you will see cost savings, without jeopardizing clinical outcome or compromising quality.
- **Precertification.** Your pharmacy benefits plan includes our precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by our Pharmacy Management Precertification Unit before they will be covered. Only your physician or pharmacist, in the case of an antibiotic or analgesic, can request prior authorization for a drug. Step-therapy is another type of precertification under which certain medications will be excluded from coverage unless you try one or more "prerequisite" drug(s) first, or unless a medical exception is obtained. The drugs requiring precertification or step-therapy are subject to change. Visit our website at www.aetnafeds.com for the most current information regarding the precertification and step-therapy lists. Ask your physician if the drugs being prescribed for you require precertification or step-therapy.
- **These are the dispensing limitations.** Prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy or by mail order may be dispensed for 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, and a 31-day up to a 90-day supply of medication for two copays. 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.

  In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filing of their medication(s) prior to departure, their pharmacist will need to contact the plan. 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.
- The Plan allows coverage of a medication refill when at least 80% of the previous prescription, according to the physician's prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a prescription refill to be covered 23 days after the last filling, thereby allowing a member to have an additional supply of their medication, in case of emergency.
- **When you do have to file a claim.** Send your itemized bill(s) to: Aetna, Pharmacy Management, P.O. Box 52444, Phoenix, AZ 85072-2444.

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

- A generic equivalent may be dispensed if it is available, and where allowed by law.

- **Specialty drugs.** Specialty drugs are medications that treat complex, chronic diseases which includes select oral, injectable and infused medications. 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 Formulary 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. If the provider supplies and administers the medication during an office visit, you will pay the applicable PCP or specialist office visit copay. If you obtain the prescribed medications directly from a participating specialty pharmacy such as Aetna Specialty Pharmacy, you will pay the applicable copay as outlined in Section 5(f) of this brochure.

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 benefit please visit www.aetnafeds.com/pharmacy or contact us at 800-537-9384 for a copy. Note that the medications and categories covered are subject to change.

- To request a printed copy of the 2018 Aetna Pharmacy Drug (Formulary) Guide, call 800-537-9384. The information in the 2018 Aetna Pharmacy Drug (Formulary) Guide is subject to change. As brand name drugs lose their patents and new generics become available on the market, the brand name drug may be removed from the formulary. Under your benefit plan, this will result in a savings to you, as you pay a lower prescription copayment for generic formulary drugs. Please visit our website www.aetnafeds.com/pharmacy for current 2018 Aetna Pharmacy Drug (Formulary) Guide information.

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies	
We cover the following medications and supplies prescribed by a licensed physician or dentist and obtained from a Plan pharmacy or through our mail order program: • Drugs approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as Not covered • Insulin • Disposable needles and syringes needed to inject covered prescribed medications • Diabetic supplies limited to: - Lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips • Prenatal vitamins (as covered under the plan's formulary) Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: $7 per covered generic formulary drug; $25 per covered brand name formulary drug; $50 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: $21 per covered generic formulary drug; $75 per covered brand name formulary drug; $150 per covered non-formulary (generic or brand name) drug.
Women's contraceptive drugs and devices • Generic oral contraceptives on our formulary list • Generic emergency contraception, including OTC when filled with a prescription • Generic injectable contraceptives on our formulary list - five (5) vials per calendar year	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	
• Diaphragms - one (1) per calendar year • Brand name Intra Uterine Device • Generic patch contraception	Nothing
• Brand name contraceptive drugs • Brand name injectable contraceptive drugs such as Depo Provera - five (5) vials per calendar year • Brand emergency contraception Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: $25 per covered brand name formulary drug; $50 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: $75 per covered brand name formulary drug; $150 per covered non-formulary (generic or brand name) drug.
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 Formulary 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 126, Specialty Drugs for more information or visit: www.aetnafeds.com/pharmacy.	**Preferred:** 20% of Plan Allowance **Non-preferred (non- formulary):** 35% of Plan Allowance (not available through mail order)
Limited benefits: • Drugs to treat erectile dysfunction are limited up to four (4) tablets per 30-day period. Contact the Plan at 800-537-9384 for dose limits. • Imitrex (limited to 48 kits per calendar year) Note: Mail order is not available.	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $7 per covered generic formulary drug; $25 per covered brand name formulary drug; $50 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: $21 per covered generic formulary drug; $75 per covered brand name formulary drug; $150 per covered non-formulary (generic or brand name) drug.

Benefit Description	You pay After the calendar year deductible...
Preventive care medications	
Preventive Care medications to promote better health as recommended by ACA. Drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. We will cover preventive medications in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations/guidance: • Aspirin • Folic acid supplements • Vitamin D supplements • Fluoride tablets • Statins Please refer to the Aetna formulary guide for a complete list of preventive drugs including coverage details and limitations: www.aetnafeds.com/pharmacy Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.	Nothing
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug) unless required by law or covered by the plan.* • *Drugs obtained at a non-Plan pharmacy except when related to out-of-area emergency care* • *Vitamins, unless otherwise stated (including prescription vitamins), nutritional supplements not listed as a covered benefit, and any food item, including infant formula, medical foods and other nutritional items, even if it is the sole source of nutrition except for nutritional formulas for the treatment of phenylketonuria branched chain ketonuria, galactosemia and homocystinuria when administered under the direction of a Plan doctor (please see Durable Medical Equipment section on page 101).* • *Medical supplies such as dressings and antiseptics* • *Lost, stolen or damaged drugs* • *Drugs for cosmetic purposes* • *Fertility drugs* • *Drugs to enhance athletic performance*	*All charges*

Preventive care medications - continued on next page

Benefit Description	You pay After the calendar year deductible...
Preventive care medications (cont.)	
• *Drugs used for the purpose of weight reduction (i.e., appetite suppressants)* • *Prophylactic drugs including, but not limited to, anti-malarials for travel* • *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 with a prescription. (See page 104). OTC drugs will not be covered unless you have a prescription and that prescription is presented at the pharmacy and processed through our pharmacy claim system.*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Program (FEDVIP) Dental Plan, your FEHB Plan will be your First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care. You are responsible for ensuring that your provider is a Plan provider.
- The deductible is $1,300 for Self Only enrollment, $2,600 for Self Plus One enrollment and $2,600 for Self and Family enrollment each calendar year. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, you will be responsible for your coinsurance amounts and copayments for eligible medical expenses.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- 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.

Dental benefits	You Pay After the calendar year deductible...
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$20 per office visit to a primary care physician $30 per office visit to a specialist See section 5(c) for facility charges.
Not covered: • *Implants*	*All charges*
Dental benefits	
We have no other dental benefits.	

Section 5(h). Wellness and Other Special features

Feature	Description
Completing Health Risk Assessments	The Plan will provide a health risk assessment through "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.
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).
Navigator®	Navigator, our secure member self-service website, provides you with the tools and personalized information to help you manage your health. Click on Navigator from www.aetnafeds.com to register and access a secure, personalized view of your benefits. With Navigator, you can: • Print temporary ID cards • Download details about a claim such as the amount paid and the member's responsibility • Contact member services at your convenience through secure messages • Access cost and quality information through Navigator's® transparency tools • View and update your Personal Health Record • Find information about the perks that come with your Plan • Access health information through Healthwise® Knowledgebase
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 800-556-1555. We provide TDD service for the hearing and speech-impaired. We also offer foreign language translation for non-English speaking members. Informed Health Line nurses cannot diagnose, prescribe medication or give medical advice.

Feature	Description
Services for the deaf and hearing impaired	800-628-3323
National Medical Excellence Program	National Medical Excellence Program helps eligible members access appropriate, covered treatment for solid organ and tissue transplants using our Institutes of Excellence™ network. We coordinate specialized treatment needed by members with certain rare or complicated conditions and assist members who are admitted to a hospital for emergency medical care when they are traveling temporarily outside of the United States. Services under this program must be preauthorized. Contact member services at 800-537-9384 for more information.

Section 5(i). 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 website at www.aetnafeds.com or call Member Services at 800-537-9384 for information on: • Aetna Navigator® • Healthwise® Knowledge base • Informed Health® Line • Hospital comparison tool and Estimate the Cost of Care tool • Medical Procedure and Price-a-Dental Procedure tools • DocFind online provider directory • Cost of care tools
Account management tools	For each HRA account holder, we maintain a complete claims payment history online through Aetna Navigator. You can access Aetna 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. • You will receive an Explanation of Benefits (EOB) after every claim. If you have an **HSA**, • You may access your account on-line through Health Equity at www.healthequity.com.
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 888-238-6240 or visit their website at www.aetnafeds.com.

Vision Discounts

With EyeMed Vision Care, you can save on eye exams, eyeglass frames and lenses, non-disposable contact lenses and solutions. You can also save on prescription and non-prescription sunglasses, LASIK eye surgery and more.

You can access EyeMed's nationwide network of eye care providers at these retail chains: Pearle Vision®, LensCrafters®, JCPenney Optical, Target Optical® and participating Sears Optical® locations. Or visit any of the thousands of participating independent eye care providers. For more information on this program or participating providers, call toll free 800-793-8616.

Hearing Discounts

The hearing discounts can help you and your family (including parents and grandparents) save on hearing exams, a large choice of leading brand hearing aids, batteries and free routine follow-up services. There are two ways for you to save at thousands of locations. Contact Hearing Care Solutions at 866-344-7756 or contact Amplifon Hearing Health Care at 877-301-0840 for more information.

Fitness Discounts

You can save on gym memberships[1] and fitness and nutrition products with services provided by GlobalFit®. Choose from thousands of gyms in the GlobalFit network. Most gyms offer a free guest pass so you can check out the gym culture, services and equipment before you sign up. You can also try out an at-home weight loss program or get one-on-one health coaching to help you quit smoking, lower stress, lose weight and more.

Visit www.globalfit.com/fitness to find a gym or call 800-298-7800 for more details.

Natural Products and Services Discounts

Save on specialty health care products like acupuncture, massage therapy and nutrition services with the ChooseHealthy Program®. Find over- the-counter vitamins, yoga equipment, homeopathic remedies and more through the ChooseHealthy website.

Weight Management Discounts

Meet your weight loss goals and save money on some of today's most popular weight loss programs and plans - NutriSystem®, Jenny Craig® and CalorieKing®. You can choose from a variety of programs and plans where you'll get one-on-one support, meal planning, online tools and much more. For more information, please call Aetna Member Services at 800-537-9384.

[1] *Participation is for new gym members only. If you belong to a gym or belonged recently, call GlobalFit to see if a discount applies.*

Discount offers provide access to discounted services and are not part of an insured plan or policy. Discount offers are rate-access offers and may be in addition to any plan benefits. Check any insurance benefits you have before using these discount offers, as those benefits may result in lower costs to you than using these discounts. Aetna makes no payment to the discount vendor. The member is responsible for the full cost of the discounted services. Aetna may receive a percentage of the fee paid to a discount vendor.

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

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

We do not cover the following:

- All services from a non-plan provider, including hospitals, surgical centers, and other facilities (except emergency care and out-of-area urgent care) that we have not approved (see Section 3).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies that are 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, and 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 or supplies given by a health care provider who lives in the same household as the patient
- 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.
- 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. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

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

Medical, hospital and prescription drug benefits

In most cases, providers and facilities file claims for you. Physicians 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 800-537-9384 or at our website at www.aetnafeds.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided 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
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

Submit your medical, hospital and vision claims to: Aetna, P.O. Box 14079, Lexington, KY 40512-4079.

Submit your dental claims to: Aetna, P.O. Box 14094, Lexington, KY 40512-4094.

Submit your pharmacy claims to: Aetna, Pharmacy Management, P.O. Box 52444, Phoenix, AZ 85072-2444

Deadline for filing your claim

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

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.

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, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

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

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

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Aetna, Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512 or calling 800-537-9384.

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

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

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

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

Disagreements between you and the CDHP 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, Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512 or calling 800-537-9384; 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 (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance Group 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 your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-537-9384. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.aetnafeds.com/resources.php. When we are the primary payor, we will 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. If the primary plan uses a preferred provider arrangement and Aetna does not, the allowable amount is the primary plan's negotiated rate. For example, we generally only make up the difference between the primary payor's benefit payment and 100% of our Plan allowance, subject to your applicable deductible, if any, and coinsurance or copayment amounts.

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

This Plan always pays secondary to:

- Any medical payment, PIP or No-Fault coverage under any automobile policy available to you,
- Any plan or program which is required by law.

You should review your automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

Note: For Motor Vehicle Accidents, charges incurred due to injuries received in an accident involving any motor vehicle for which no-fault insurance is available, regardless of whether any such policy is designated as secondary to health coverage.

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Recovery rights related to Workers' Compensation

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

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

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

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

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

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

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

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

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

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

Clinical Trials

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

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- 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.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

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

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

Medicare has four parts:

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

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

Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213, (TTY: 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 by your Plan provider, or prior authorized by us as required.

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 800-537-9384 or see our website at www.aetnafeds.com.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

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

Example: High Option

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$0	$0
Out-of-Pocket Maximum	$4,500 Self Only/$6,850 Self Plus One and Self and Family	$4,500 Self Only/$6,850 Self Plus One and Self and Family
Primary Care Physician	$20 per visit	$0 per visit
Specialist	$35 per visit	$0 per visit
Inpatient Hospital	$200 per day up to $600 per admission	$0 per admission
Outpatient Hospital	$450 copay	Nothing
Rx	Tier 1 - $7 Tier 2 - $25 Tier 3 - 40% up to a $240 maximum Tier 4 – Specialty preferred (30-day supply) 30% Tier 5: Specialty non-preferred (30-day supply) 50%	Tier 1 - $7 Tier 2 - $25 Tier 3 - 40% up to a $240 maximum Tier 4 – Specialty preferred (30-day supply) 30% Tier 5: Specialty non-preferred (30-day supply) 50%
Rx – Mail Order (31-90 day supply)	Tier 1 - $7 Tier 2 - $50 Tier 3 - 40% up to a $720 maximum	Tier 1 - $7 Tier 2 - $50 Tier 3 - 40% up to a $720 maximum

You can find more information about how our plan coordinates benefits with Medicare in by calling Customer Service at 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 the 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 800-MEDICARE (800-633-4227), (TTY: 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. Please call us at 888-788-0390. We do not waive cost-sharing for your FEHB coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, we will not waive any of our copayments, coinsurance, or deductibles. 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 800-832-2640. See **Important Notice from Aetna about our Prescription Drug Coverage and Medicare** on the first inside page of this brochure for information on Medicare Part D.

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Clinical Trials Cost Categories

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

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- 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.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 28.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 28.

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 a fixed expense 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

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.

Experimental or investigational service

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.

Open Access HMO

You can go directly to any network specialist for covered services without a referral from your primary care physician. Whether your covered services are provided by your selected primary care physician (for your PCP copay) or by another participating provider in the network (for the specialist copay), you will be responsible for payment which may be in the form of a copay (flat dollar amount) or coinsurance (a percentage of covered expenses). While not required, it is highly recommended that you still select a PCP and notify Member Services of your selection (800-537-9384). If you go directly to a specialist, you are responsible for verifying that the specialist is participating in our Plan. If your participating specialist refers you to another provider, you are responsible for verifying that the other specialist is participating in our Plan.

Plan allowance

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

We may take into account factors such as the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility, and the prevailing charge in other areas in determining the Plan allowance for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where 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.

Preventive care

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

Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Respite care	Care furnished during a period of time when your family or usual caretaker cannot, or will not, attend to your needs. Respite care is not covered.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Urgent care and urgent care claims	Covered benefits required in order to prevent serious deterioration of your health that results from 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. 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 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 Altius Health Plans. (Note: This plan is a part of Aetna Inc., as noted throughout the brochure, correspondence should be sent to Aetna accordingly.)
You	You refers to the enrollee and each covered family member.

High Deductible Health Plan (HDHP) Definitions

Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for those services. See page 28.
Health Reimbursement Arrangement (HRA)	A health reimbursement arrangement (HRA) is an employer-funded account that is set up to reimburse qualified medical expenses incurred by you and your dependents (including your spouse) who are enrolled in your employer-sponsored plan, up to a maximum dollar amount for a coverage period. The HRA is not portable if you leave the Federal government or switch to another plan. See the chart beginning on page 83.
Health Savings Account (HSA)	A health savings account (HSA) is a trust or custodial account that is set up with a qualified trustee to pay or reimburse certain medical expenses incurred by you, your spouse, and dependents you may claim for tax purposes (even if they are not enrolled in your health plan). You must be enrolled in a high deductible health plan (HDHP) and meet certain other eligibility requirements to qualify for an HSA. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan. See the chart beginning on page 83.

Section 11. Other Federal Programs

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

Important information about Four 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. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

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

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

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)**, can help protect your family from burdensome funeral costs and unexpected loss of your income.

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,600 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

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

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

- If you are a new or newly eligible employee you have 60 days from you 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 877-FSAFEDS, 877-372-3337, (TTY 866-353-8058), Monday through Friday, 9 a.m. until 9 p. m., Eastern Time.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia, but it may be limited. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision Insurance

All vision plans will provide comprehensive eye examinations and coverage for your choice of either lenses and frames or contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/dental or www.opm.gov/vision. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 877-888-3337 (TTY: 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. Long term care can be received in your home, in a nursing home, in an assisted living facility or in adult day care. You must apply, answer health questions, (called underwriting) and be approved for enrollment. Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Your qualified relatives can apply even if you do not. 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 800-LTC-FEDS (800-582-3337) (TTY: 800-843-3557) or visit www.ltcfeds.com.

The Federal Employees' Group Life Insurance Program - *FEGLI*

Peace of Mind for You and Your Family

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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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 High Option of Altius Health Plans - 2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. This is a summary of 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical preventive care (specified services only)	Nothing	34
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $35 specialist	33
• Teladoc	$30 per consult	33
Services provided by a hospital:		
• Inpatient	$200 per day up to $600 per admission copay	58
• Outpatient	$450 per visit	59
Emergency benefits:		
• In-area	$200 for emergency room services	63
• Out-of-area	$200 for emergency room services	63
Mental health and substance misuse disorder treatment:	Regular cost-sharing	65
Prescription drugs:		
• Retail pharmacy	**30-day supply** – $7 preferred generic; $25 preferred brand name; 40% coinsurance up to $240 maximum for non-preferred (non-formulary)	70
• Mail order	**90-day supply** – $7 preferred generic; $50 preferred brand name; 40% coinsurance up to $720 maximum for non-preferred (non-formulary)	70
• Specialty drugs	30% preferred; 50% non-preferred	71
Dental care:	See schedule of Dental Benefits	74
Vision care:	Annual eye examinations and refractions - Nothing	42
Special features:	Nothing for flexible benefits option; services for deaf, hard of hearing, and non-English speaking members; high risk pregnancies	131
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4,500/individual or $6,850/ for Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection	29

Summary of benefits for the Standard Option of Altius Health Plans - 2018

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard Option Benefits	You pay	Page
Medical preventive care (specified services only)	Nothing	34
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $40 specialist	33
• Teladoc	$40 per consult	33
Services provided by a hospital:		
• Inpatient	15% coinsurance	58
• Outpatient	$650 per visit	59
Emergency benefits		
• In-area	$250 for emergency room services	63
• Out-of-area	$250 for emergency room services	63
Mental health and substance misuse disorder treatment:	Regular cost-sharing	65
Prescription drugs:		
• Retail pharmacy	**30-day supply** - $7 preferred generic; $35 preferred brand name; 50% coinsurance up to $240 maximum non-preferred (non-formulary)	70
• Mail order	**31-90-day supply** - $7 preferred generic; $70 preferred brand name; 50% coinsurance up to $720 maximum non-preferred (non-formulary)	70
• Specialty drugs	30% preferred; 50% non-preferred	71
Dental care:	Accidental Dental Only	74
Vision care:	Annual eye examinations and refractions - Nothing	42
Special features:	Nothing for flexible benefits option; services for deaf, hard of hearing, and non-English speaking members; high risk pregnancies	131
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/individual or $6,850/ for Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection	29

Summary of benefits for the High Deductible Health Plan (HDHP) of Altius Health Plans - 2018

- **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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- All covered services listed below, except specified preventive care services, are subject to the calendar year deductible of $1,300 for Self Only, $2,600 for Self Plus One, and $2,600 for Self and Family. Once you satisfy your calendar year deductible, Traditional medical coverage begins.
- In 2018, for each month you are eligible for the Health Savings Account (HSA) premium pass through, we will contribute to your HSA $54.16 per month for Self Only enrollment, $108.33 for Self Plus One enrollment or $108.33 per month for Self and Family enrollment. For the HSA, you may use your HSA or pay out-of-pocket to satisfy your calendar year deductible. For the Health Reimbursement Arrangement (HRA), your health charges are applied to your annual HRA Fund of $650 for Self Only, $1,300 for Self Plus One, and $1,300 for Self and Family.

HDHP Benefits	You Pay	Page
Medical preventive care (specified services only)	Nothing (not subject to deductible)	89
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $30 specialist	94
• Teladoc	$30 per consult	94
Services provided by a hospital:		
• Inpatient	10%	114
• Outpatient	$500 per visit	115
Emergency benefits:		
• In-area	$200 for emergency room services	119
• Out-of-area	$200 for emergency room services	119
Mental health and substance misuse disorder treatment:	Regular cost sharing	121
Prescription drugs:		
• Retail pharmacy	**30-day supply** – $7 preferred generic; $25 preferred brand name; $50 non-preferred **NOTE**: Deductible does not apply to Preventive Medications	126
• Mail order	**31-90-day supply** – $21 preferred generic; $75 preferred brand name; $150 non-preferred	126
• Specialty drugs	20% preferred; 35% non-preferred	127

HDHP Benefits	You Pay	Page
Dental care:	Accidental injury benefit only: regular cost sharing. No benefit for routine dental care	130
Vision care:	Annual eye examinations and refractions - Nothing	100
Special features:	Nothing for flexible benefits option; services for deaf, hard of hearing, and non-English speaking members; high risk pregnancies	131
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after $5,000/Self Only or $6,850/Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection	29

2018 Rate Information

For 2018 FEHB plan premium information, please see:

https://www.opm.gov/healthcare-insurance/tribal-employers/benefits-premiums/ or contact your tribal employer's Human Resources department.