Aetna Open Access®

http://www.aetnafeds.com
Customer service 1-800/537-9384

2016

A Health Maintenance Organization

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

Serving: Arizona, California, Georgia, Pennsylvania, Tennessee, and Washington.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 18
- Summary of benefits: Page 95

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 16 for requirements.

Enrollment code for Phoenix & Tucson, AZ
WQ1 Self Only
WQ3 Self Plus One
WQ2 Self and Family

Enrollment code for Los Angeles & San Diego, CA:
2X1 Self Only
2X3 Self Plus One
2X2 Self and Family

Enrollment code for Athens & Atlanta, GA:
2U1 Self Only
2U3 Self Plus One
2U2 Self and Family

Enrollment code for Pittsburgh & Western PA:
YE1 Self Only
YE3 Self Plus One
YE2 Self and Family

Enrollment code for Memphis, TN :
UB1 Self Only
UB3 Self Plus One
UB2 Self and Family

Enrollment code for Seattle & Spokane, WA:
C31 Self Only
C33 Self Plus One
C32 Self and Family

Special notice: The Plan has reduced its service and enrollment area by terminating enrollment codes HF1, HF2 (Las Vegas, NV). Members in this enrollment code who do not change health plans during Open Season will not have health benefits for 2016.

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Aetna About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of Aetna* under our contract (CS 2867) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 1-800/537-9384 or through our website: www.aetnafeds.com. The address for the Aetna administrative office is:

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

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

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized on page 18. Rates are shown at the end of this brochure.

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

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

* The Aetna companies that offer, underwrite or administer benefits coverage are Aetna Health Inc., Aetna Health of California Inc., Aetna Life Insurance Company, Aetna Dental Inc., and/or Aetna Dental of California Inc.

Our health insurance plan in the State of Washington is an Exclusive Provider Organization (EPO) underwritten by Aetna Life Insurance Company (ALIC). You are required to receive services from our network of providers. There are no out-of-network benefits.

Plain Language

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

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-800/537-9384 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about 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.

3. Get the results of any test or procedure.

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

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

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

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

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

Patient Safety Links

- www.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

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

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

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

- **Minimum value standard (MVS)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- **Family member coverage**

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

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

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

- **Children's Equity Act**

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

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

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

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

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

- **When benefits and premiums start**

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

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

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

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

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

  You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

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

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

- **Finding replacement coverage**

  In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 1-800/537-9384 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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory or visit our website at www.aetnafeds.com.

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 Option

- You can see participating network specialists without a referral (Open Access).
- You can choose between our Basic Dental or Dental PPO option. Under Basic Dental, you can access preventive care for a $5 copay and other services at a reduced fee. Under the PPO option, if you see an in-network dentist, you pay nothing for preventive care after a $20 annual deductible per member. You may also utilize non-network dentists for preventive care, but at reduced benefit levels after satisfying the $20 annual deductible per member. You pay all charges for other services when utilizing non-network dentists.
- You receive a $100 reimbursement every 24 months for glasses or contact lenses.

We have Open Access benefits - Does not apply to members in the state of California (Enrollment Code 2X).

Members in the state of California must continue to obtain referrals from their PCPs to access specialist care. If your primary care physician is part of an IPA, you must be referred to specialists within or approved by that IPA.

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

This Open Access Plan is available to members in our FEHBP service area. If you live or work in an Open Access HMO service area, you can go directly to any network specialist for covered services without a referral from your primary care physician. Note: 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 at 1-800/537-9384. **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.**

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 copayments, coinsurance, or deductible.

This is a direct contract prepayment Plan, which means that participating providers are neither agents nor employees of the Plan; rather, they are independent doctors and providers who practice in their own offices or facilities. The Plan arranges with licensed providers and hospitals to provide medical services for both the prevention of disease and the treatment of illness and injury for benefits covered under the Plan.

Specialists, hospitals, primary care physicians and other providers in the Aetna network have agreed to be compensated in various ways:

- Per individual service (fee-for-service at contracted rates),
- Per hospital day (per diem contracted rates),
- Under capitation methods (a certain amount per member, per month), and
- By Integrated Delivery Systems ("IDS"), Independent Practice Associations ("IPAs"), Physician Medical Groups ("PMGs"), Physician Hospital Organizations ("PHOs"), behavioral health organizations and similar provider organizations or groups that are paid by Aetna; the organization or group pays the physician or facility directly. In such arrangements, that group or organization has a financial incentive to control the costs of providing care.

One of the purposes of managed care is to manage the cost of health care. Incentives in compensation arrangements with physicians and health care providers are one method by which Aetna attempts to achieve this goal. You are encouraged to ask your physicians and other providers how they are compensated for their services.

Your rights

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/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

If you want more information about us, call 1-800/537-9384 or write to Aetna at P.O. Box 550, Blue Bell, PA 19422-0550. You may also visit our website at www.aetnafeds.com.

Your medical and claims records are confidential

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

Medical Necessity

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

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

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

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

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 Abuse

Behavioral health services (e.g. treatment or care for mental disease or illness, alcohol abuse and/or substance abuse) 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 Aetna to coordinate your transition from the inpatient setting to the next level of care (discharge planning), or to register you for specialized programs like disease management, case management, or our prenatal program. In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments.

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

- **Concurrent Review** — The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
- **Discharge Planning** — Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/ benefits to be utilized by you upon discharge from an inpatient stay.
- **Retrospective Record Review** — The purpose of retrospective record review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of health care services. Our effort to manage the services provided to you includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Member Services

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

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

Privacy Notice

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

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

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

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

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

If you want more information about us, call 1-800/537-9384, or write to Aetna, Federal Plans, PO Box 550, Blue Bell, PA 19422-0550. You may also contact us by fax at 215/775-5246 or visit our website at www.aetnafeds.com.

Aetna HMO 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:

California, Los Angeles & San Diego areas – Enrollment code **2X** – Los Angeles, Orange, San Diego, San Luis Obispo, Santa Barbara and Ventura counties, and portions of Kern, Riverside and San Bernardino counties as defined below:

Kern County: All towns **except** Cantil, China Lake, Garlock, Johannesburg, Mojave and Ridgecrest

Riverside County: All towns **except** Blythe, Desert Center and Mesa Verde

San Bernardino County: All towns **except** Baker, Big River, Cadiz, Cima, Danby, Earp, Essex, Ivonpah, Kelso, Lake Havasu, Needles, Nipton, Parker Dam, Rice and Vidal.

Aetna Open Access Service Area

The following service areas will be for our Aetna Open Access HMO. Under these plans, members may see network specialists without obtaining a referral from their primary care physician (PCP). To enroll in this Plan, you must live in or work in our service area. Our health insurance plan in the State of Washington is an Exclusive Provider Organization (EPO) underwritten by Aetna Life Insurance Company (ALIC). You are required to receive services from our network of providers. There are no out-of-network benefits. This is where our providers practice. Our service area is:

Arizona, Phoenix and Tucson areas– Enrollment code **WQ** – Cochise, Graham, Gila, Maricopa, Mohave, Pima, Santa Cruz, Yavapai and Yuma counties and portions of the following county as defined by the towns below:

Pinal: Apache Junction, Casa Grande, Coolidge, Eloy, Florence, Kearny, Maricopa, Picacho, Queen Creek, Red Rock, Sacaton, Stanfield and Superior.

Georgia, Athens and Atlanta areas – Enrollment code **2U** – Barrow, Bartow, Butts, Carroll, Cherokee, Clarke, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Floyd, Forsyth, Fulton, Gordon, Greene, Gwinnett, Hall, Heard, Henry, Jackson, Jasper, Lamar, Morgan, Newton, Oconee, Oglethorpe, Paulding, Pickens, Pike, Polk, Rockdale, Spalding and Walton counties.

Pennsylvania, Pittsburgh and Western PA areas– Enrollment code **YE** – Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Cameron, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Forest, Greene, Indiana, Jefferson, Lawrence, Mckean, Mercer, Potter, Somerset, Venango, Warren, Washington and Westmoreland counties.

Tennessee, Memphis area – Enrollment code **UB** – Crockett, Dyer, Fayette, Haywood, Lauderdale, Shelby and Tipton counties.

Washington, Seattle and Spokane areas - Enrollment code **C3** - Adams, Asotin, Benton, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Orieille, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, Whitman and Yakima counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent 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 2016

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- **Self Plus One enrollment type has been added effective January 1, 2016.**

Changes to High Option

- Enrollment Code 2U. Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 97.
- Enrollment Code 2X. Your share of the non-Postal premium will decrease for Self Only and decrease for Self and Family. See page 97.
- Enrollment Code C3. Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 98.
- Enrollment Code UB. Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 98.
- Enrollment Code WQ. Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 97.
- Enrollment Code YE. Your share of the non-Postal premium will decrease for Self Only and decrease for Self and Family. See page 98.
- **Catastrophic protection out-of-pocket maximum -** The Plan will decrease the out-of-pocket maximum from $8,000 to $6,850 for Self Plus One and Self and Family enrollments. (See page 26)
- **Teladoc** - The Plan will now offer telehealth consultation services. Specialist copayment applies. (Not available for CA members) (See page 31)
- **Services that require plan approval (other services) -** The Plan updated its list of services that require plan approval which now includes: dental implants, transportation by plane, diagnostic studies such as sleep studies, dialysis and private duty nursing, breast cancer genetic testing, ventricular assist devices and outpatient surgery at non-participating ambulatory surgery center when referred by a participating provider. (See page 22)
- **Maternity care –** The Plan now allows a total of three (3) days or less for vaginal delivery or a total of five (5) days or less for cesarean delivery. (See page 24)
- **Emergency inpatient admission –** The Plan now requires the member, member's representative, physician or hospital to inform the Plan within one (1) business day following the emergency admission of the member. (See page 24)
- **Infertility -** The Plan will no longer cover artificial insemination. (See page 36)
- **Alternative medicine treatment –** The Plan will add acupuncture limited to 20 visits per person per calendar year. (See page 42)
- **Physical and occupational therapy –** The Plan will change coverage to now provide 60 total visits per person per calendar year for physical or occupational therapy or combination of both. (See page 38)
- **Speech therapy –** The Plan will change coverage to now provide 60 total visits per person per calendar year for speech therapy. (See page 39)
- **Specialty prescription drugs –** The Plan will add a 5th Tier for non-preferred specialty drugs. Members will pay 50% up to a maximum of $500 per drug for a 30-day supply. (See page 64)
- **Prescription drugs –** The Plan will now require members to utilize at least 80% of a prescribed medication before it can be refilled. (See page 62)

- **Limited quantity prescription drugs –** The Plan will change the cost sharing for Imitrex and Erectile Dysfunction drugs from 50% of the Plan's allowance to the Plan's applicable Formulary copayments. (See page 64)
- **Surgical treatment of morbid obesity (Bariatric Surgery) –** The Plan no longer requires the condition to persist for at least two (2) years. (See page 44)
- **Service Area Expansions** - The Plan expanded its service area in the enrollment codes and states below as follows:
  - Pennsylvania (code YE)– Cameron, Clearfield, Crawford, Elk, Forest, Mckean, Potter and Warren counties.

Section 3. How you get care

Open Access HMO

This Open Access Plan is available to our members in those FEHBP service areas identified starting on page 16. 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 (1-800/537-9384**). 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 1-800/537-9384 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 get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance and you will not have to file claims. If you use our Open Access program you can receive covered services from a participating network provider without a required referral from your primary care physician or by another participating provider in the network.

- **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. First, you and each family member should 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 or coordinate 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. We will help you select a new one.

- **Specialty care**

If you are enrolled in Enrollment Code 2X, your primary care physician will refer you to a specialist for needed care. If you need laboratory, radiological and physical therapy services, your primary care physician must refer you to certain plan providers. Your primary care physician may refer you to any participating specialist for other specialty care. If your primary care physician is part of an IPA, you will be referred to IPA-approved specialists. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a Plan gynecologist, (within an IPA, you must see an IPA-approved gynecologist), for a routine well-woman exam, including a Pap smear, one visit every 12 months from the last date of service, and an unlimited number of visits for gynecological problems and follow-up care as described in your benefit plan without a referral. You may also see a Plan mental health provider, Plan vision specialist or a Plan dentist without a referral.

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

- For CA (code 2X) only, if you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. If he or she decides to refer you to a specialist, ask if you can see your current specialist. 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 Member Services department immediately at 1-800/537-9384. 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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your 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*.

- **Inpatient hospital admission**

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

- **Other services**

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:

- For infertility services you must contact the Infertility Case Manager at 1-800/575-5999;
- You must obtain precertification from your primary care doctor and Aetna for covered follow-up care with non-participating providers.
- Certain non-emergent surgery, including but not limited to obesity surgery, lumbar disc and spinal fusion surgery, reconstructive procedures and correction of congenital defects, sleep apnea surgery, TMJ surgery and dental implants, and joint grafting procedures;
- Covered transplant surgery, see Section 5(b);
- Transportation by fixed-wing aircraft (plane);
- Skilled nursing facilities, rehabilitation facilities, and inpatient hospice; and skilled nursing under Home Health Care;
- Certain mental health services, including residential treatment centers, partial hospitalization programs, intensive outpatient treatment programs including detoxification and electroconvulsive therapy, psychological and neuropsychological testing, biofeedback and amytal interview;
- Certain oral and injectable drugs before they can be prescribed including but not limited to botulinum toxin, alpha-1-proteinase inhibitor, palivizumab(Synagis), erythropoietin therapy, intravenous immunoglobulin, growth hormone, blood clotting factors and interferons when used for hepatitis C;
- Certain outpatient imaging and diagnostic studies such as sleep studies, CT scans, MRIs, MRAs, nuclear stress tests, and GI tract imaging through capsule endoscopy;
- Proton beam radiotherapy;

- Cognitive skills development;
- Dialysis and private duty nursing;
- Certain wound care such as hyperbaric oxygen therapy;
- Certain limb prosthetics;
- Cochlear device and/or implantation;
- Percutaneous implant of nerve stimulator;
- BRCA and breast cancer genetic testing;
- Gender reassignment surgery;
- Ventricular assist devices;
- Outpatient surgery at a non-participating ambulatory surgery center when referred by a participating provider.

You or your physician must obtain an approval for certain durable medical equipment (DME) including but not limited to electric or motorized wheelchairs, electric scooters, electric beds, and customized braces. Members must call 1-800/537-9384 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 1-800/537-9384 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 then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

- **Urgent care claims**

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

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800/537-9384. 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 1-800/537-9384. 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 days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

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

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

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

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

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

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

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

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

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

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

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

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

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your cost for covered services

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

Cost-sharing

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

Copayments

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

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

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- We have a deductible of $20 per member per year if you elect our PPO dental option.

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.

Coinsurance

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

Example: In our Plan, you pay 50% of our allowance for drugs to treat sexual dysfunction.

Differences between our Plan allowance and the bill

- Network Providers agree to accept our Plan allowance so if you use a network provider, you never have to worry about paying the difference between our Plan allowance and the billed amount for covered services.
- Non-Network Providers (for Dental PPO Option only): If you use a non-network provider for preventive dental care, you will have to pay 50% of our negotiated rate and the difference between our Plan allowance and the billed amount.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $4,000 for Self Only or $6,850 for Self Plus One, or $6,850 for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. The Self Plus One or Self and Family out-of-pocket maximum must be satisfied by one or more family members before the plan will begin to cover eligible medical expenses at 100%. 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 (Note: $5 copayments for DMO preventive care and $20 deductible for PPO preventive care count towards your out-of-pocket maximum. All other dental service expenses do not count toward your out-of-pocket maximum).

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.

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

High Option Benefits

See page 18 for how our benefits changed this year. Pages 95-96 is a benefits summary of our High Option.

Section 5. High Option Benefits Overview

This Plan offers only a High Option. Our benefit package is described in Section 5. Make sure that you review the benefits carefully.

The High Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. 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 Open Access benefits, contact us at 1-800/537-9384 or on our website at www.aetnafeds.com.

Our benefit package offers the following unique features:

- You can see participating network specialists without a referral (Open Access), except for California.
- You have more choices for your dental coverage. You can choose between our Basic Dental or our Dental PPO option. Under Basic Dental, you can access preventive care for a $5 copay and other services at a reduced fee. Under the PPO option, if you see an in-network dentist, you pay nothing for preventive care after a $20 annual deductible per member. Participating network PPO dentists may offer members other services at discounted fees. Discounts may not apply in all states. You may also utilize non-network dentists for preventive care, but at reduced benefit levels, and after a $20 annual deductible per member. You pay all charges for other services when utilizing non-network dentists.
- You receive a $100 reimbursement every 24 months for glasses or contact lenses.
- You can use Aetna Health Connections Disease Management Programs which are available for thirty-four conditions.

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.
- 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.
- If you live or work in an Aetna Open Access HMO service area, you should select a PCP by calling Member Services at 1-800/537-9384.
- If you live or work in an Aetna Open Access HMO service area, you do not have to obtain a referral from your PCP to see a specialist **(does not apply to enrollment code 2X).**

Benefit Description	You pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office - Office medical evaluations, examinations, and consultations - Second surgical or medical opinion	$20 per primary care physician (PCP) visit $35 per specialist visit
• During a hospital stay • In a skilled nursing facility	Nothing
• In an urgent care center	$50 per visit
• At home	$25 per PCP visit $35 per specialist visit
• Teladoc (not available for CA members) Please see www.aetnafeds.com for information on Teladoc service. Note: Members will receive a Teladoc welcome kit explaining the benefit.	$35 per consult
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound	Nothing if you receive these services during your office visit; otherwise if service performed by another provider, $20 per PCP visit $35 per specialist visit

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

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	**High Option**
• Electrocardiogram and electroencephalogram(EEG)	Nothing if you receive these services during your office visit; otherwise if service performed by another provider, $20 per PCP visit $35 per specialist visit
Diagnostic tests limited to: • Bone density tests - diagnostic • CT scans/MRIs/PET scans • Diagnostic angiography • Genetic testing - diagnostic* • Nuclear medicine • Sleep studies Note: The services need precertification. See "Services requiring our prior approval" on page 22. *Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's medical condition.	$75 copay
• Genetic Counseling and Evaluation for BRCA Testing • Genetic Testing for BRCA-Related Cancer* *Note: Requires precertification. See "Services requiring our prior approval" on page 22.	Nothing
Preventive care, adult	**High Option**
Routine physicals: • One exam every 2 calendar years up to age 65 • One exam every calendar year age 65 or older Routine screenings, such as: • Routine urine test • Total Blood Cholesterol • Fasting lipid profile • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Lung cancer screening - one screening annually from age 55 years and older • Digital rectal examination (DRE) – one annually for men aged 40 and older • Colorectal Cancer Screening, including - Fecal occult blood test yearly starting at age 50; - Sigmoidoscopy, screening – every five years starting at age 50; - Colonoscopy screening – every ten years starting at age 50	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Note: Physician consultation for colorectal screening visits prior to the procedure are not considered preventive. • Chlamydia screening – one annually • Abdominal Aortic Aneurysm Screening – Ultrasonography, one 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 at 1-800/537-9384 for information on whether a specific test is considered routine.	Nothing
Well woman care, including, but not limited to: • Routine well woman exam (one visit per calendar year) • Routine Pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections. • Annual counseling and screening for human immune-deficiency virus. • Generic contraceptive methods and counseling. (See page 63) • Screening and counseling for interpersonal and domestic violence.	Nothing
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Routine Osteoporosis Screening: • For women 65 and older • At age 60 for women at increased risk	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) such as: • Tetanus, Diphtheria and Pertussis (Tdap) vaccine as a single dose for those 19 years of age and above • Tetanus-Diphtheria (Td) booster every 10 years • Influenza vaccine, annually • Varicella (chicken pox) for ages 19 to 49 years without evidence of immunity to varicella • Pneumococcal vaccine, age 65 and older • Human papillomavirus (HPV) vaccine for age 18 through age 26 • Herpes Zoster (Shingles) vaccine for age 60 and older	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay
Preventive care, adult (cont.)	**High Option**
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	
Not covered: • Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.	*All charges*
Preventive care, children	**High Option**
• We follow the American Academy of Pediatrics (AAP) recommendations for preventive care and immunizations. Go to www.aetnafeds.com for the list of preventive care and immunizations recommended by the American Academy of Pediatrics. • Screening examination of premature infants for Retinopathy of Prematurity-A retinal eye screening exam performed by an ophthalmologist for infants with low birth weight (<1500g) or gestational age of 32 weeks or less and infants weighing between 1500 and 2000g or gestational age of more than 32 weeks with an unstable clinical course. • Hearing loss screening of newborns provided by a participating hospital before discharge. • Dietary and nutritional counseling for obesity - unlimited visits. Note: Some tests provided during a routine physical may not be considered preventive. Contact member services at 1-800/537-9384 for information on whether a specific test is considered routine.	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) - 7 routine exams from birth to age 12 months - 3 routine exams from age 12 months to 24 months - 3 routine exams from age 24 months to 36 months - 1 routine exam per year thereafter to age 22 • Examinations, such as: - Vision screenings 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 22) *For routine eye refraction, see Vision Services	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	**High Option**
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ and HHS at https://www.healthcare.gov/preventive-care-benefits/.	
Not covered: • Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.	*All charges*
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care - includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will 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 including the initial examination of a newborn child covered under a Self Plus One or Self and Family enrollment. 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 maternity care (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). Note: Also see our Maternity Management Program (Aetna's Beginning Right ® Maternity Program) in Section 5 (h).	No copay for prenatal care or the first postpartum care visit $20 for PCP visit 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.
Breastfeeding support, supplies and counseling for each birth	Nothing
Not covered: Home births	*All charges*

Benefit Description	You pay
Family planning	**High Option**
A range of voluntary family planning services limited to: • 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
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*
Infertility services	**High 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 (6 months for women age 35 or older). Diagnosis and treatment of infertility such as: • Testing for diagnosis and surgical treatment of the underlying cause of infertility	$35 per specialist visit
Not covered: • *Any assisted reproductive technology (ART) procedure or services related to such procedures, including but not limited to in-vitro fertilization, gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection or* • *Artificial insemination and monitoring of ovulation:* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI) or* • *Any charges associated with care required to obtain ART services (e.g. office, hospital, ultrasounds, laboratory tests, etc); and any charges associated with obtaining sperm for any ART procedures* • *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*

Infertility services - continued on next page

Benefit Description	You pay
Infertility services (cont.)	**High 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 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 19mI U/ml or greater on day 3 of menstrual cycle.* • *Cost of home ovulation predictor kits or home pregnancy kits* • *Drugs related to the treatment of non-covered benefits* • *Infertility services that are not reasonably likely to result in success*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections Note: You pay the applicable copay for each visit to a doctor's office including each visit to a nurse for an injection.	$20 per PCP visit $35 per specialist visit
Allergy serum	Nothing
Not covered: Provocative food testing and Sublingual allergy desensitization	*All charges*
Treatment therapies	**High 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 47. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis Note: Copayment does not apply for peritoneal dialysis when self administered. Copayment will apply if services are rendered in the home by a plan provider. • Intravenous (IV)/Infusion Therapy • Growth hormone therapy (GHT) Note: Growth hormone therapy is covered under Medical Benefits; office copay applies. We cover growth hormone injectables under the prescription drug benefit.	$35 per visit

Treatment therapies - continued on next page

Benefit Description	You pay
Treatment therapies (cont.)	**High Option**
Note: We will only cover GHT when we preauthorize the treatment. Call 1-800/245-1206 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and it is authorized by Aetna. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$35 per visit
Not covered: Applied Behavioral Analysis (ABA)	*All charges*
Physical and occupational therapies	**High 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: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient therapy is covered under Hospital/Extended Care Benefits. • Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome Note: Physical therapy treatment of lymphedemas following breast reconstruction surgery is covered under the Reconstructive surgery benefit - see section 5(b).	$35 per visit Nothing during a covered inpatient admission
Not covered: • *Long-term rehabilitative therapy*	*All charges*
Pulmonary and cardiac rehabilitation	**High Option**
• Two consecutive months (60 consecutive days) per condition per member per calendar year for pulmonary rehabilitation to treat functional pulmonary disability. • Cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or a myocardial infarction is provided for up to 3 visits a week for a total of 18 visits.	$35 per visit Nothing during a covered inpatient admission
Not covered: Long-term rehabilitative therapy	*All charges*
Habilitative Therapy	**High Option**
• Habilitative services for children under age 19 with congenital or genetic birth defects including, but not limited to, autism or an autism spectrum disorder, and cerebral palsy. Treatment is provided to enhance the child's ability to function. Services include occupational therapy, physical therapy and speech therapy. Note: See Occupational therapy, physical therapy and speech therapy for plan coverage and limitations.	$35 per visit Nothing during a covered inpatient admission

Benefit Description	You pay
Speech therapy	**High Option**
• 60 visits per person, per calendar year	$35 per visit Nothing during a covered inpatient admission
Hearing services (testing, treatment, and supplies)	**High Option**
• Audiological testing and medically necessary treatment for hearing problems • Hearing testing for children through age 17 (see *Preventive care, children*) • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. (See *Orthopedic and prosthetic devices* section and the note referring to Section 5(b) and 5(c) for hospital and ambulatory surgery center benefits). Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* Note: Discounts on hearing exams, hearing services, and hearing aids are also available. Please see the Non-FEHB Benefits section of this brochure for more information.	$20 per PCP visit $35 per specialist visit
Not covered: • *Hearing aids, testing and examinations for them* • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• Treatment of eye diseases and injury	$20 per PCP visit $35 per specialist visit
• Corrective eyeglasses and frames or contact lenses (hard or soft) for adults age 19 and older once per 24-month period.	All charges over $100
• Corrective eyeglasses and frames or contact lenses (hard or soft) for children through age 18 once 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, Children* for eye exams for children	$35 per specialist 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*

Benefit Description	You pay
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$20 per PCP visit $35 per specialist visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open manipulation or fixation)* • *Foot orthotics* • *Podiatric shoe inserts*	*All charges*
Orthopedic and prosthetic devices	**High 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 • Ostomy supplies specific to ostomy care (quantities and types vary according to the ostomy, location, construction, etc.) 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 or internal prosthetic device, see Section 5(b) Surgical procedures. For information regarding facility fees associated with obtaining orthopedic and prosthetic devices, see Section 5(c).	30% of our 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; all charges over $500
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *All charges over $500 for hair prosthesis*	*All charges*

Benefit Description	You pay
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Contact Plan at 1-800/537-9384 for a complete list of covered DME. Some covered items include: • Oxygen • Dialysis equipment • Hospital beds (Clinitron and electric beds must be preauthorized) • Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Insulin pumps and related supplies such as needles and catheters Note: You must get your DME from a participating DME provider. Some DME may require precertification by you or your physician.	30% of our Plan allowance
Not covered: • *Elastic stockings and support hose* • *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	**High Option**
• Home health services ordered by a Plan Physician and provided by nurses and home health aides through a participating home health care agency. Home health services include skilled nursing services provided by a licensed nursing professional; services provided by a physical therapist, occupational therapist, or speech therapist; and services of a home health aide when provided in support of the skilled home health services. Home health services are limited to 3 visits per day with each visit equal to a period of 4 hours or less. Your Plan Physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications. Note: Short-term physical, speech, or occupational therapy accumulate toward the applicable benefit limit (See the physical, speech and occupational therapy benefit in this section). Note: Skilled nursing under Home health services must be precertified by your Plan physician.	20% of our Plan allowance
Not covered: • *Nursing care for the convenience of the patient or the patient's family.* • *Custodial care, i.e. home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative and appropriate for the active treatment of a condition, illness, disease or injury.* • *Services provided by a family member or resident in the member's home.*	*All charges*

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	**High Option**
• *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	**High Option**
Chiropractic services up to 20 visits per member per calendar year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	$35 per specialist visit
Not covered: • *Any services not listed above*	*All charges*
Alternative medicine treatments	**High Option**
Acupuncture - 20 visits per member per calendar year. Note: See page 52 for our coverage of acupuncture when provided as anesthesia for covered surgery. See Section 5 Non-FEHB benefits available to Plan members for discount arrangements.	$35 per visit *Nothing when provided as anesthesia for covered surgery*
Not covered: Other alternative medical treatments including but not limited to: • *Acupuncture other than stated above* • *Applied kinesiology* • *Aromatherapy* • *Biofeedback* • *Craniosacral therapy* • *Hair analysis* • *Reflexology*	*All charges*
Educational classes and programs	**High 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	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High Option**
• Kidney failure • Low back pain • Sickle Cell disease To request more information on our disease management programs, call 1-800/537-9384.	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.
Not covered: *Applied Behavioral Analysis (ABA)*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- 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 the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual has a body mass index (BMI) exceeding 40 or a BMI greater than 35 in conjunction with documented significant co-morbid conditions (such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea or refractory hypertension). - Eligible members must be age 18 or over or have completed full growth. - 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. - 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 PCP visit $35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High Option**
We will consider: - Open or laparoscopic Roux-en-Y gastric bypass; or - Open or laparoscopic biliopancreatic diversion with or without duodenal switch; or - Sleeve gastrectomy; or - Laparoscopic adjustable silicone gastric banding (Lap-Band) procedures. • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization for men (e.g., vasectomy) • Treatment of burns • Skin grafting and tissue implants • Gender reassignment surgery* - The Plan will provide coverage for the following when the member meets Plan criteria: • Surgical removal of breasts for female-to-male patients • Surgical removal of uterus and ovaries in female-to-male and testes in male-to-female • Reconstruction of external genitalia** * Subject to medical necessity ** Note: Requires Precertification. See "Services requiring our prior approval" on page 22. You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 1-800/537-9384.	$20 per PCP visit $35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.
Voluntary sterilization for women (e.g., tubal ligation)	Nothing
Not covered: • *Reversal of voluntary surgically-induced sterilization* • *Surgery primarily for cosmetic purposes* • *Radial keratotomy and laser surgery, including related procedures designed to surgically correct refractive errors* • *Routine treatment of conditions of the foot; see Foot care* • *Gender reassignment services that are not considered medically necessary*	*All charges*

Benefit Description	You pay
Reconstructive surgery	**High 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 and developmental anomalies are cleft lip, cleft palate, webbed fingers, and webbed toes. All surgical requests must be preauthorized. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedema - breast prostheses and surgical bras and replacements (*see Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$35 per specialist visit Nothing for the surgery. 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	**High Option**
Oral surgical procedures, that are medical in nature, such as: • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ (must be preauthorized); • Excision of tumors and cysts; and • Removal of bony impacted wisdom teeth. Note: When requesting oral and maxillofacial services, please check DocFind or call Member Services at 1-800/537-9384 for a participating oral and maxillofacial surgeon.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.
Not covered: • Dental implants • Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	*All charges*

Benefit Description	You pay
Organ/tissue transplants	**High 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 22. • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas; Pancreas/Kidney (simultaneous)	$35 per specialist visit Nothing for the surgery. 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 - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)* - Hemoglobinopathies - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Ependymoblastoma - 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 Nothing for the surgery. See section 5(c) for facility charges.
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (ie., Fanconi's, PNH, Pure Red Cell Asplasia) - 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 Nothing for the surgery. 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 - Advanced non-Hodgkin's lymphoma - Breast cancer	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
- 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 (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Breast cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High 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 treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.	
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four allogenic bone marrow/stem cell transplant donors in addition to the testing of family members.	
Clinical trials must meet the following criteria: A. The member has a current diagnosis that will most likely cause death within one year or less despite therapy with currently accepted treatment; or the member has a diagnosis of cancer; AND B. *All* of the following criteria must be met: 1. Standard therapies have not been effective in treating the member or would not be medically appropriate; and 2. The risks and benefits of the experimental or investigational technology are reasonable compared to those associated with the member's medical condition and standard therapy based on at least two documents of medical and scientific evidence (as defined below); and 3. The experimental or investigational technology shows promise of being effective as demonstrated by the member's participation in a clinical trial satisfying ALL of the following criteria: a. The experimental or investigational drug, device, procedure, or treatment is under current review by the FDA and has an Investigational New Drug (IND) number; and 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:	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High Option**
a. Not be treated "off protocol," and b. Must actually be enrolled in the trial.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.
Not covered: • *The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials. Terminal illness means a medical prognosis of 6 months or less to live); and* • *Costs of data collection and record keeping that would not be required but for the clinical trial; and* • *Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs"); and* • *Items and services provided by the trial sponsor without charge* • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services (including Acupuncture - when provided as anesthesia for a covered surgery) provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: For sedation or anesthesia relating to dental services performed in a dental office, see Section 5(g), Dental benefits. Note: When the anesthesiologist is the primary giver of services, such as for pain management, the specialist copay applies.	Nothing

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.
- 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
Inpatient hospital	**High 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. 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, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	$250 per day up to a maximum of $1,000 per admission
Not covered: • *Whole blood and concentrated red blood cells not replaced by the member* • *Non-covered facilities, such as nursing homes and schools* • *Custodial care, rest cures, domicilary or convalescent cares*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
Not covered (con't): • *Personal comfort items, such as telephone and television* • *Private duty nursing*	*All charges*
Outpatient hospital or ambulatory surgical center	**High 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 • Pathology Services • Administration of blood, blood plasma, and other biologicals • Blood products, derivatives and components, artificial blood products and biological serum • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), penile implants, defibrillator, surgically implanted breast implant following mastectomy, and lenses following cataract removal. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Note: Preventive care services are not subject to copays listed.	$175 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
Complex diagnostic tests limited to: • Bone density tests - diagnostic • CT scans/MRIs/PET scans • Diagnostic angiography • Genetic testing - diagnostic* • Nuclear medicine • Sleep studies Note: These services need precertification. See "Services requiring our prior approval" on page 22.	$75 copay

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center (cont.)	**High Option**
*Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's medical condition.	$75 copay
Not covered: • *Whole blood and concentrated red blood cells not replaced by the member*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 60-day limit per calendar year when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	30% of our Plan allowance
Not covered: Custodial care	*All charges*
Hospice care	**High Option**
Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of a Plan doctor, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less.	Nothing
Ambulance	**High Option**
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member.	Ambulance - $100 copay Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency* • *Ambulette service* • *Ambulance transportation for member convenience or reasons that are not medically necessary* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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 Aetna 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. 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 Aetna as soon as possible.

Emergencies outside our Service Area:

If you are traveling outside your Aetna service area or if you are a student who is away at school, you are covered for emergency and urgently needed care. 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, earaches, or high fever are considered "urgent care" outside your Aetna 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.

Follow-up Care after Emergencies

All follow-up care should be coordinated by your PCP or network specialist. Follow-up care with non-participating providers is only covered with a referral from your primary care physician and pre-approval from Aetna. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

Benefit Description	You pay
Emergency within our service area	**High Option**
Emergency care at a doctor's office .	$20 per PCP visit $35 per specialist visit
Emergency care at an urgent care center	$50 per visit
Emergency care as an outpatient at a hospital (Emergency Room), including doctors' services.	$125 per visit Note: If you are admitted from the Emergency Room to a hospital, the copay is waived.
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**High Option**
Emergency care at a doctor's office	$35 per specialist visit
Emergency care at an urgent care center	$50 per visit
Emergency care as an outpatient at a hospital (Emergency Room), including doctors' services.	$125 per visit Note: If you are admitted from the Emergency Room to a hospital, the copay is waived.
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*
Ambulance	**High Option**
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member.	Ambulance - $100 copay Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.

Ambulance - continued on next page

Benefit Description	You pay
Ambulance (cont.)	**High Option**
Air or sea ambulance may be covered. Prior approval is required. Note: See 5(c) for non-emergency service.	Ambulance - $100 copay Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency.* • *Ambulette service.* • *Air ambulance without prior approval.* • *Ambulance transportation for member convenience or for reasons that are not medically necessary.* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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. Preauthorization is required for the following:
  - Any intensive outpatient care (minimum of 2 hours per day or six hours per week - can include group, individual, family or multi-family group psychotherapy, etc.)
  - Outpatient detoxification
  - Partial hospitalization
  - Any inpatient or residential care
  - Psychological or neuropsychological testing
  - Outpatient electroconvulsive therapy
  - Biofeedback and amytal interview
  - Psychiatric home health care
- Aetna can assist you in locating participating providers in the Plan, unless your needs for covered services extend beyond the capability of the affiliated providers. Emergency care is covered (See Section 5(d), Emergency services/accidents). You can receive information regarding the appropriate way to access the behavioral health care services that are covered under your specific plan by calling Member Services at 1-800/537-9384. 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 for denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay
Professional services	**High Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy)	$35 per visit

Professional services - continued on next page

Benefit Description	You pay
Professional services (cont.)	**High Option**
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$35 per visit
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	$35 per outpatient visit
Inpatient hospital or other covered facility	**High 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	$250 per day up to a maximum of $1,000 per admission
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$35 per outpatient visit
Not covered	**High Option**
• *Educational services for treatment of behavioral disorders* • *Services in half-way houses* • *Applied Behavioral Analysis (ABA)*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- This is a five-tier open formulary pharmacy plan. A formulary is a list of generic and brand-name drugs that your health plan covers. Each drug is associated with a tier on the formulary list. Tier-one is generic drugs on our formulary list, Tier-two is brand name drugs on our formulary list, Tier-three is drugs not on our formulary list, Tier-four is preferred specialty drugs and Tier-five is non-preferred specialty drugs. Each tier has a separate out-of-pocket cost.
- We cover prescribed drugs and medications, as described in the chart beginning on the 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.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- 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 must fill prescriptions at a participating Plan retail pharmacy for up to a 30-day supply, or by mail order for a 31-day up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay, (retail pharmacy) and for a 31-day up to a 90-day supply of medication for two copays (mail order). In no event will the copay exceed the cost of the prescription drug. For retail pharmacy transactions, you must present your Aetna Member ID card at the point of sale for coverage. Please call Member Services at 1-800/537-9384 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. If you obtain your 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 licensed doctors and covered in accordance with the Plan's drug formulary. The Plan's formulary does not exclude medications from coverage, but requires a higher copayment for nonformulary drugs. Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Visit our website at www.aetnafeds.com to review our Formulary Guide or call 1-800/537-9384.

- **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 may be covered for up to a 30-day supply. Members **must** obtain a 31-day up to a 90-day supply of covered prescription medication through mail order. In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available, unless your physician specifically requires a brand name.

  In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filing of their medication(s) prior to departure, their pharmacist will need to contact Aetna. Coverage of additional prescriptions will only be allowed if there are refills remaining on the member's current prescription or a new prescription has been issued by their physician. The member is responsible for the applicable copayment for the additional prescription.
- Aetna allows coverage of a medication 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. Our specialty drug program is called Aetna Specialty CareRx medications which include select oral, injectable and infused medications. Because of the complex therapy needed, a pharmacist or nurse should check in with you often during your treatment. The first fill of these medications can be obtained through a participating retail pharmacy or specialty pharmacy. However, you must obtain all subsequent refills through a participating specialty pharmacy such as Aetna Specialty Pharmacy.

Certain Aetna Specialty CareRx medications identified with a (+) next to the drug name may be covered under the medical or pharmacy section of this brochure depending on how and where the medication is administered. 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 CareRx benefit please visit: www.AetnaSpecialtyCareRx.com. You can also visit www.aetnafeds.com for the 2016 Aetna Specialty CareRx list or contact us at 1-800/537-9384 for a copy. Note that the medications and categories covered are subject to change.

- To request a printed copy of the Aetna Preferred Drug (Formulary) Guide, call 1-800/537-9384. The information in the Aetna Preferred 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 at www.aetnafeds.com for current Aetna Preferred Drug (Formulary) Guide information.

Benefit Description	You pay
Covered medications and supplies	**High 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* • 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 Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/ coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered generic formulary drug; $35 per covered brand name formulary drug; and $100 per covered non-formulary (generic or brand name) drug. Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 per covered generic formulary drug; $70 per covered brand name formulary drug; and $200 per covered non-formulary (generic or brand name) drug.
We cover the following medications based on the US Preventive Services Task Force A and B recommendations. A prescription is required and must be processed through our pharmacy claim system. • Aspirin for adults age 45 and older (325 mg in strength or less) • Iron supplementation for children ages 6 to 12 months • Oral fluoride for children ages 6 months through age 5 • Vitamin D for adults age 65 and older • Folic acid supplementation for females	Nothing
Women's contraceptive drugs and devices • Generic oral contraceptives on our formulary list • Generic injectable contraceptives on our formulary list - 5 vials per calendar year	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• Generic emergency contraception, including OTC when filled with a prescription • Diaphragms - 1 per calendar year	Nothing
• Brand name contraceptive drugs • Brand name injectable contraceptive drugs such as Depo Provera - 5 vials per calendar year • Brand emergency contraception	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $35 per covered brand name formulary drug; and $100 per covered non-formulary (generic or brand name) drug. Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $70 per covered brand name formulary drug; and $200 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 CareRx medications identified with a (+) next to the drug name may be covered under the medical or pharmacy section of this brochure. Please refer to page 62, Specialty Drugs for more information or visit**:** www.AetnaSpecialtyCareRx.com.	Up to a 30-day supply per prescription or refill: Preferred: 50% up to $250 maximum Non-preferred: 50% up to $500 maximum
Limited benefits: • Drugs to treat erectile dysfunction are limited up to 4 tablets per 30-day period. Contact the Plan at 1-800/537-9384 for dose limits. • Imitrex (limited to 48 kits per calendar year) Note: Mail order not available	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered generic formulary drug; $35 per covered brand name formulary drug; and $100 per covered non-formulary (generic or brand name) drug.
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* • *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, 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 41).*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
• *Medical supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes* • *Lost, stolen or damaged drugs* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs used for the purpose of weight reduction, (i.e., appetite suppressants)* • *Prophylactic drugs including, but no 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 43.) 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:

- You have two different dental options, Basic Dental or Dental PPO, from which to choose. New members are automatically enrolled in the Basic Dental option. If you want to switch to the Dental PPO option, you must call on or before the 15th of the month to have your coverage in the Dental PPO option be effective on the first of the following month (i.e., call on 1/8 and your coverage is effective on 2/1, but if you call on 1/17, your coverage will not be effective until 3/1).
- 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.
- **Under the Basic Dental option, you must select a Plan primary care dentist before receiving care.** Your selected Plan primary care dentist must provide or arrange covered care. **Services rendered by non-Plan dentists are not covered.** The Plan will cover 100% of the charges for the preventive, diagnostic and restorative procedures shown on the next page. You will be responsible for a copayment of $5 for each office visit regardless of the number of procedures performed.
- **Note: You will be covered automatically under this Basic Dental option unless you enroll in the Dental PPO option by calling Member Services at 1-800/537-9384.**
- Under the Dental PPO option, the Plan covers 100% of the charges (after satisfaction of a $20 annual deductible per member) for those preventive, diagnostic, and restorative procedures shown on the next page when using a participating network dentist. Participating network PPO dentists may offer members other services at discounted fees. Discounts may not be available in all states.
- You also have the choice to use non-network dentists under this Dental PPO option for those preventive, diagnostic and restorative procedures shown on the next page, but the Plan will cover only 50% of the standard negotiated rate we would have paid an in-network PPO provider. You are responsible for any difference between the amount billed and the amount paid by the Plan for the eligible services listed in this section, plus your annual $20 deductible. **Any other dental services rendered by non-network dentists are not covered.**
- We cover hospitalization for dental procedures only when a nondental 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 on the next pages.
- 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
Accidental injury benefit	**High Option**
Coverage is limited to palliative treatment and those services listed on the following schedule. Note: See Oral and maxillofacial surgery, section 5(b).	See benefits below

Dental benefits begin on next page

Dental Benefits	You Pay After the calendar year deductible...		
Service	**Basic Dental**	**PPO-Network**	**PPO Non-Network**
Annual Deductible	No Deductible	$20 per member per year.	$20 per member per year.
Diagnostic Office visit for routine oral evaluation — limited to 2 visits per year Bitewing x-rays — limited to 2 sets of bitewing x-rays per year Complete x-ray series — limited to 1 complete x-ray series in any 3 year period Periapical x-rays and other dental x-rays — as necessary Diagnostic casts **Preventive** Prophylaxis (cleaning of teeth) — limited to 2 treatments per year Topical application of fluoride — limited to 2 courses of treatment per year to children under age 18 Oral hygiene instruction (not covered under PPO) **Restorative (Fillings)** Amalgam/Composite 1 surface, primary or permanent Amalgam/Composite 2 surfaces, primary or permanent Amalgam/Composite 3 surfaces, primary or permanent Amalgam/Composite or more surfaces, primary or permanent **Prosthodontics Removable** Denture adjustments (complete or partial/upper or lower) **Endodontics** Pulp cap — direct Pulp cap — indirect Note: Members can take advantage of our network discounts on other dental procedures when using participating network dentists for services.	No Deductible $5 per visit	Nothing	50% of our negotiated rate and any difference between our allowance and the billed amount.

Basic Dental Option

Note: Basic Dental option services shown in this section are only covered when provided by your selected participating primary care dentist in accordance with the terms of your Plan. ***If rendered by a participating specialist, they are provided at reduced fees. Pediatric dentists are considered specialists.*** Certain other services will be provided by your selected participating primary care dentist at reduced fees. Specific fees vary by area of the country. Call Member Services at 1-800/537-9384 for specific fees for your procedure. All member fees must be paid directly to the participating dentist**. Services provided by a non-network dentist are not covered.**

Each employee and dependent(s) automatically will be enrolled in the Basic Dental option, unless you enroll in the Dental PPO option.

Each employee and dependent ***must*** select a primary care dentist from the directory when participating in the Basic Dental option and include the dentist's name on the enrollment form. You also may call Member Services at 1-800/537-9384.

Dental PPO Option

Under this option, you have the choice to use our participating Dental PPO network dentists or a non-network dentist. The benefit levels are different, based on whether or not the dentist participates in our network. You must contact Member Services at 1-800/537-9384 to select this option.

If you call on or before the 15th of the month, your coverage in the Dental PPO option will be effective on the first of the following month (i.e., call on 1/8 and your coverage is effective on 2/1, but if you call on 1/17, your coverage will not be effective until 3/1).

If you decide to switch back to the Basic Dental Option, you must call Member Services at 1-800/537-9384. The same timing rules apply. You must also select a Primary Care Dentist. Your prior Primary Care Dentist will not be reassigned to you, unless you specifically request it.

Dental PPO In-Network Option

The plan covers 100% of the charges (after satisfaction of the $20 annual deductible per member) for those preventive, diagnostic, and restorative procedures shown **on the previous page** when using a participating network dentist. Participating network PPO dentists may offer members others services at discounted fees. Please call Member Services at 1-800/537-9384 for specific fees for your procedure.

Dental PPO Non-Network Option

Dentists' normal fees generally are higher than Aetna's negotiated fees. **Non-participating dentists will be paid only for those services shown on the previous page.** Payment will be based on the standard negotiated rate provided to participating general dentists in the same geographic area. Members may be able to take advantage of discounts when using network dentists. Discounts may not be available in all states.

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Aetna Navigator	Aetna Navigator, our secure member self-service website, provides you with the tools and personalized information to help you manage your health. Click on Aetna Navigator from www.aetnafeds.com to register and access a secure, personalized view of your Aetna benefits. With Aetna Navigator, you can: • Review PCP selections • Print temporary ID cards • Download details about a claim such as the amount paid and the member's responsibility • Contact member services at your convenience through secure messages • Access cost and quality information through Aetna's transparency tools • View and update your Personal Health Record • Find information about the member extras that come with your plan • Access health information through Healthwise® Knowledgebase Registration assistance is available toll free, Monday through Friday, from 7am to 9pm Eastern Time at 1-800/225-3375. Register today at www.aetnafeds.com.
Services for deaf and hearing-impaired	1-800/628-3323

Special features-continued on next page

Informed Health® Line	Provides eligible members with telephone access to registered nurses experienced in providing information on a variety of health topics. Informed Health Line is available 24 hours a day, 7 days a week. You may call Informed Health Line at 1-800/556-1555. 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.
Maternity Management Program	Aetna's Beginning Right®Maternity Management Program provides services, information and resources to help improve high risk pregnancy outcomes. Features of the program include a pregnancy risk survey, obstetrical nurse care coordination, comprehensive educational information on prenatal care, labor and delivery, newborn and baby care, a smoking-cessation program, and more. To enroll in the program, call toll-free 1-800/CRADLE-1.
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 1-800/537-9384 for more information.
Reciprocity benefit	If you need to visit a participating primary care physician for a covered service, and you are 50 miles or more away from home you may visit a primary care physician from our plan's approved network. • Call 1-800/537-9384 for provider information and location • Select a doctor from 3 primary care doctors in that area • The Plan will authorize you for one visit and any tests or X-rays ordered by that primary care physician • You must coordinate all subsequent visits through your own participating primary care physician.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, 1-800/537-9384 or visit their website at www.aetnafeds.com.

Aetna Vision SM Discounts

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

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

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

Aetna HearingSM Discount Program

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

Aetna FitnessSM Discount Program

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

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

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

Aetna Natural Products and Services SM Discount Program

Offers reduced rates on acupuncture, chiropractic care, massage therapy, and dietetic counseling as well as discounts on over-the-counter vitamins, herbal and nutritional supplements, natural products, and yoga equipment. Through Vital health Network, you can receive a discount on online consultations and information, please call Aetna Member Services at 1-800/537-9384.

Aetna Weight Management SM Discount Program

The Aetna Weight Management Discount Program provides you and your eligible family members with access to discounts on eDiets® diet plans and products, Jenny® weight loss programs, Calorie King® memberships and products and Nutrisystem® weight loss meal plans. You can choose from a variety of programs and plans to meet your specific weight loss goals and save money. For more information, please call Aetna Member Services at 1-800/537-9384.

Health Insurance Plan for Individuals

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

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. 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 1-800/537-9384, or at our website at www.aetnafeds.com.

When you must file a claim – such as for services you receive 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 without 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, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

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

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

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing Aetna, Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512 or calling 1-800/537-9384.

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

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

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

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

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; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address, if you would like to receive our decision via email. Please note that by providing your email address, you may receive our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or

	c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond 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 file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-800/537-9384. 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 Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

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

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

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

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone at 1-877-888-3337, (TTY 1-877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Recovery rights related to Workers' Compensation

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

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

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

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

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

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

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

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

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

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

Clinical trials

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

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan. See page 49.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs. See page 52.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs. See page 52.

When you have Medicare

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

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

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

- **Should I enroll in Medicare?**

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you 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.

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

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800/537-9384.

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

You can find more information about how our plan coordinates benefits with Medicare by calling 1-800/537-9384 or see our website www.aetnafeds.com.

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.

Benefit Description	Member Cost without Medicare	Member Cost with Medicare Part B
Deductible	$0	$0
Out-of-Pocket Maximum	$4,000 Self Only/$6,850 Self Plus One or Self and Family	$4,000 Self Only/$6,850 Self Plus One or Self and Family
Primary Care Physician	$20 per visit	$20 per visit
Specialist	$35 per visit	$35 per visit
Inpatient Hospital	$250 per day up to $1,000 per admission	$250 per day up to $1,000 per admission
Outpatient Hospital	$175 per visit	$175 per visit
Rx (30-day supply)	Tier 1 - $10 Tier 2 - $35 Tier 3 - $100 Tier 4 – Preferred Specialty 50% up to $250 maximum Tier 5 - Non-preferred Specialty 50% up to $500 maximum	Tier 1 - $10 Tier 2 - $35 Tier 3 - $100 Tier 4 – Preferred Specialty 50% up to $250 maximum Tier 5 - Non-preferred Specialty 50% up to $500 maximum
Rx – Mail Order (31-90 day supply)	2x retail copay	2x retail copay

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

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

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

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

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

This Plan and our Medicare Advantage Plan: You may enroll in our Medicare Advantage Plan and also remain enrolled in our FEHB Plan. If you are an annuitant or former spouse with FEHBP coverage and are enrolled in Medicare Parts A and B, you may enroll in our Medicare Advantage Plan if one is available in your area. For more information, please call us at 1-888/788-0390. **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 or coinsurance. If you enroll in a Medicare Advantage Plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage Plan so we can correctly coordinate benefits with Medicare.

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

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

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

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 (FDA); 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. See page 49.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs. See page 51.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs. See page 51.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 26.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 26.

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. See page 26.

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 amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 26.

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

This does not apply to the State of California (Enrollment Code 2X). 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 (1-800/537-9384). **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 the service or supply in the geographic area where it is furnished. 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 were treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

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

Precertification

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

Certain health care services, such as hospitalization or outpatient surgery, require precertification with Aetna to ensure coverage for those services.

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.

Referral

For California members only: To receive coverage for any non-emergency service and necessary follow-up care outside those provided by your PCP, the member must have a written or electronic referral made by the PCP or no coverage will be provided (with the exception of some direct access providers within the network).

For Open Access members, you do not need a referral for specialist care within our network.

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	Covered benefits required in order to prevent serious deterioration of your health that results from an unforeseen illness or injury if you are temporarily absent from our service area and receipt of the health care service cannot be delayed until your return to our service area.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800/537/9384. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and We refer to Aetna.
You	You refers to the enrollee and each covered family member.

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 three Federal programs that complement the FEHB Program

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

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

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

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket 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 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 children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

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

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

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

The Federal Long Term Care Insurance Program – *FLTCIP*

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

Notes

Notes

Notes

Index

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

Summary of benefits for the High Option of the Aetna Open Access Plan - 2016

- **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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $35 specialist	31
Services provided by a hospital:		
• **Inpatient**	$250 per day up to a maximum of $1,000 per admission	53
• **Outpatient**	$175 per visit	54
Emergency benefits:		
• **In-area**	$125 per visit	57
• **Out-of-area**	$125 per visit	57
Mental health and substance abuse treatment:	Regular cost-sharing	59
Prescription drugs: In no event will the copay exceed the cost of the prescription drug.		
• Retail Pharmacy: For up to a 30-day supply per prescription unit or refill	$10 copay per generic formulary drug; $35 copay per brand name formulary drug; and $100 copay per non-formulary drug (generic or brand name).	63
• Mail Order Pharmacy: For a 31-day up to a 90-day supply per prescription unit or refill	$20 copay per generic formulary drug; $70 copay per brand name formulary drug; and $200 copay per non-formulary drug (generic or brand name).	63
Specialty Medications: For up to a 30-day supply per prescription unit or refill	Preferred: 50% up to a $250 maximum per prescription Non-preferred: 50% up to $500 maximum per prescription	64
Dental care:	Various copays, coinsurance, reduced fees or deductibles	66
Vision care:	$35 copay per visit. All charges over $100 for eyeglasses or contacts per 24-month period	39

High Option Benefits	You pay	Page
Special features: Flexible benefits option, Aetna Navigator, Services for the deaf and hearing-impaired, Informed Health Line, Maternity Management Program, National Medical Excellence Program, and Reciprocity benefit.	Contact Plan at 1-800/537-9384	69-70
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after $4,000/Self Only enrollment or $6,850/Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection.	26

2016 Rate Information for the Aetna Open Access Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to United States Postal Service employees.

Postal Category 1 rates apply to career bargaining unit employees.

Postal Category 2 rates apply to career non-bargaining unit employees.

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

Postal rates do not apply to non-career Postal employees, Postal retirees, or associate members of any Postal employee organization who are not career Postal employees.

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Phoenix & Tucson, AZ							
High Option Self Only	WQ1	$213.37	$192.25	$462.30	$416.54	$180.39	$192.25
High Option Self Plus One	WQ3	$461.02	$514.06	$998.88	$1,113.79	$488.45	$514.06
High Option Self and Family	WQ2	$488.50	$496.34	$1,058.42	$1,075.40	$469.20	$496.34
Los Angeles & San Diego, CA							
High Option Self Only	2X1	$213.37	$75.24	$462.30	$163.02	$63.38	$75.24
High Option Self Plus One	2X3	$461.02	$203.25	$998.88	$440.37	$177.64	$203.25
High Option Self and Family	2X2	$488.50	$189.05	$1,058.42	$409.61	$161.91	$189.05
Athens & Atlanta, GA							
High Option Self Only	2U1	$213.37	$292.08	$462.30	$632.84	$280.22	$292.08
High Option Self Plus One	2U3	$461.02	$691.72	$998.88	$1,498.72	$666.11	$691.72
High Option Self and Family	2U2	$488.50	$675.77	$1,058.42	$1,464.17	$648.63	$675.77

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Pittsburgh & Western PA							
High Option Self Only	YE1	$213.37	$114.25	$462.30	$247.54	$102.39	$114.25
High Option Self Plus One	YE3	$461.02	$353.50	$998.88	$765.91	$327.89	$353.50
High Option Self and Family	YE2	$488.50	$334.15	$1,058.42	$723.99	$307.01	$334.15
Memphis, TN							
High Option Self Only	UB1	$213.37	$170.17	$462.30	$368.70	$158.31	$170.17
High Option Self Plus One	UB3	$461.02	$512.09	$998.88	$1,109.53	$486.48	$512.09
High Option Self and Family	UB2	$488.50	$494.34	$1,058.42	$1,071.07	$467.20	$494.34
Seattle & Spokane WA							
High Option Self Only	C31	$213.37	$91.65	$462.30	$198.58	$79.79	$91.65
High Option Self Plus One	C33	$461.02	$367.09	$998.88	$795.36	$341.48	$367.09
High Option Self and Family	C32	$488.50	$347.89	$1,058.42	$753.76	$320.75	$347.89