Aetna HealthFund® HDHP and Aetna Direct Plan

www.aetnafeds.com

Customer service 888-238-6240

aetna

2026

An Individual Practice Plan with a High Deductible Health Plan (HDHP) Option and an Individual Practice Plan with a Consumer Driven Health Plan (CDHP) option

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See FEHB Facts for details. This Plan is accredited. See Section 1.

Serving: In all 50 states and the District of Columbia

Underwritten and administered by: Aetna Life Insurance Company

Enrollment in this Plan is limited: You must live or work in our geographic service area to enroll. See Section 1 for requirements.

Postal Employees and Annuitants are no longer eligible for this plan. (unless currently under Temporary Continuation of Coverage)

Enrollment codes for this Plan:

224 High Deductible Health Plan (HDHP) - Self Only
226 High Deductible Health Plan (HDHP) – Self Plus One
225 High Deductible Health Plan (HDHP) – Self and Family

N61 Aetna Direct Plan - Self Only
N63 Aetna Direct Plan - Self Plus One
N62 Aetna Direct Plan - Self and Family

IMPORTANT
- Rates: Back Cover
- Changes for 2026: Page 23
- Summary of Benefits: Page 197

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 73-828

Important Notice from Aetna About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return**. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https ://www. medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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

- Visit www. medicare.gov for personalized help.
- Call 800-MEDICARE 800-633-4227, TTY 877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of our High Deductible Health Plan and Aetna Direct under Aetna contract (CS 2900) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. If you are deaf, hearing impaired or speech impaired, you can contact our Customer Service at 888-238-6240 (TTY:711). If you need ASL providers see our website at www. aetnafeds.com. The address for the Aetna* administrative office is:

Aetna Life Insurance Company
Federal Plans
PO Box 818047
Cleveland, OH 44181-8047

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 Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2026, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefits are effective January 1, 2026, and changes are summarized in Section 2. Rates are shown at the end of this brochure.

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

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered 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 Healthcare 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 phone or to people you do not know, except for your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services 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 888-238-6240 and explain the situation.
  - If we do not resolve the issue:

CALL THE HEALTH CARE FRAUD HOTLINE
877-499-7295

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

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

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless they are disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a family member, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining 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.

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks.

Take these simple steps:

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

2. **Keep and bring a list of all the medications you take.**
   - Bring the actual medication or give your doctor and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications 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 medication is what the doctor ordered. Ask the pharmacist about the medication if it looks different than you expected.
   - Read the label and patient package insert when you get your medication, including all warnings and instructions.
   - Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
   - Contact your doctor or pharmacist if you have any questions.
   - Understanding both the generic and brand names for all of your medication(s) is important. This helps ensure you do not receive double dosing from taking both a generic and a brand of the same medication. It also helps you avoid taking a medication to which you are allergic.

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

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

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

Patient Safety Links

For more information on patient safety, please visit:

- www. jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www. jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www. ahrq.gov/patients-consumers. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www. bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

Preventable Healthcare Acquired Conditions ("Never Events")

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

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct Never Events, if you 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. 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, give you other plans' brochures and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family**

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

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

The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Selfand Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status including your marriage, divorce, annulment or when your child reaches age 26. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in 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 your spouse by valid common-law marriage from a state that recognizes common-law marriages) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren
Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children
Coverage: 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
Coverage: 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
Coverage: 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
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- 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 coverage, 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 lowest-cost nationwide plan option as determined by OPM.

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 does not 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 does not 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, except if you are an active employee and change your plan at open season. 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 processed according to the 2026 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2025 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

You may be eligible for spouse equity coverage or assistance enrolling in a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

If you are an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member 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: https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- **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). 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, or if you are a covered 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 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.

- **Converting to individual coverage**

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

- Your coverage under TCC or the spouse equity law ends;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 888-238-6240 or visit our website at www.aetnafeds.com.

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

This Plan is an individual practice plan offering you a choice of a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component or a Direct Plan including a Consumer Driven Health Plan (CDHP) with a medical fund. HDHPs have higher annual deductibles than other types of FEHB plans. FEHB Program HDHP's also offer Health Savings Accounts or Health Reimbursement Arrangements. Please see below for more information about these features.

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

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

General features of our High Deductible Health Plan (HDHP)

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

- An HSA in which the Plan will automatically deposit $66.67 per month/Self Only or $133.34 per month/Self Plus One or $133.34 per month/Self and Family.
- The ability to make voluntary contributions to your HSA of up to $3,600/Self Only or $7,150/Self Plus One or $7,150/Self and Family per year. If you are age 55 or older, you may also make an additional contribution of up to $1,000 for 2026.

You may consider:

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

The type and extent of covered services, and the amount we allow, may be different from other plans. Read our brochure carefully to understand the benefits and features of this HDHP. The IRS website at www. treasury.gov/resource-center/faqs/Taxes/Pages/Health-Savings-Accounts.aspx has additional information about HDHPs.

Preventive care services for your HDHP

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

Annual deductible for your HDHP

The annual deductible of $1,800 for Self Only, $3,600 for Self Plus One or $3,600 for Self and Family in-network and $2,600 for Self Only, $5,200 for Self Plus One or $5,200 for Self and Family out-of-network, must be met before Plan benefits are paid for care other than preventive care services. Once an individual meets a $3,400 deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One and Self and Family deductible can be satisfied by one or more family members. In-network and Out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.

Health Savings Account (HSA) under HDHP

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

- You may use the money in your HSA to pay all or a portion of your annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the Plan will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA) under HDHP

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

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

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

Catastrophic protection for your HDHP

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, and coinsurance cannot exceed $6,900 for Self Only enrollment, and $13,800 for a Self Plus One or Self and Family enrollment for in-network services or $9,000 for Self Only enrollment, and $18,000 for a Self Plus One or Self and Family enrollment when you utilize out-of-network services. Once an individual meets the Self Only out-of-pocket maximum under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical expenses at 100%. The remaining balance of the Self Plus One or Self and Family out-of-pocket maximum can be satisfied by one or more family members. In-network and Out-of-network out-of-pocket maximums do not cross apply and will need to be met separately in order for eligible medical expenses to be paid at 100%.

General features of our Aetna Direct Plan

Our Direct Plan is a comprehensive medical plan. You can see participating or nonparticipating providers without a referral. For 2026, the Direct plan offers:

- A consumer-controlled annual Medical Fund of $900/Self only enrollment, $1,800/Self Plus One enrollment or $1,800/ Self and Family enrollment to help you pay for eligible expenses. You use your Medical Fund first for covered medical expenses, then you need to satisfy your annual deductible. Once your deductible has been satisfied, the Traditional Medical Plan benefits will apply.
- Opportunity to rollover unused Medical Funds for use in future years.
- Online tools to help you manage your money and your health.
- Freedom to choose the providers you wish to see -- with no referrals.

- A cap that limits the total amount you pay annually for eligible expenses.
- If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible and your coinsurance for most medical services. (See Section 5 for details) Note: The annual deductible will be waived for pharmacy benefits, but cost sharing as outlined in Section 5(f) will still apply if Medicare Part A and B are primary.

Preventive Care Services for your Direct Plan

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

Deductible for your Direct Plan

Once you have exhausted your medical fund, the annual deductible of $1,600 for Self Only enrollment, $3,200 for Self Plus One enrollment and $3,200 for Self and Family enrollment for in-network and $1,600 for Self Only enrollment, $3,200 for Self Plus One enrollment and $3,200 for Self and Family enrollment for out-of-network, must be met before Traditional Medical Plan benefits are paid for care other than preventive care services. Once an individual meets the Self Only deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One and Self and Family deductible can be satisfied by one or more family members. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin. Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible and your coinsurance for most medical services. (See Section 5 for details)

Catastrophic protection for your Direct Plan

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and coinsurance, cannot exceed $6,000 for Self Only enrollment, and $12,000 for a Self Plus One or Self and Family enrollment for in-network services or $7,000 for Self Only enrollment, and $14,000 for a Self Plus one or Self and Family enrollment when you utilize out-of-network services. Once an individual meets the Self Only out-of-pocket maximum under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical expenses at 100%. The remaining balance of the Self Plus One or Self and Family out-of-pocket maximum can be satisfied by one or more family members. In-network and Out-of-network out-of-pocket maximums do not cross apply and will need to be met separately in order for eligible medical expenses to be paid at 100%.

Health education resources and accounts management tools

We have online, interactive health and benefits information tools to help you make more informed health decisions (See Section 5(i)).

We have Network Providers

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

Network Providers

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

Non-Network Providers

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

Your rights and responsibilities

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

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

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

If you want more information about us, call 888-238-6240 or write to Aetna at P.O. Box 818047, Cleveland, OH 44181-8047. You may also visit our website at www. aetnafeds.com.

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

Your medical and claims records are confidential

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

Medical Necessity

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

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

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

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

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

Ongoing Reviews

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

Authorization

Certain services and supplies under this Plan may require authorization by us to determine if they are covered benefits under this Plan. See Section 3, “Other Services” under “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 MCG Health Care Guidelines® to guide the precertification, concurrent review and retrospective review processes. To the extent certain utilization review/patient management functions are delegated to integrated delivery systems, independent practice associations or other provider groups (“Delegates”), such Delegates utilize criteria that they deem appropriate.

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

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

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

- **Concurrent Review** The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.

- **Discharge Planning** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/ benefits to be utilized by you upon discharge from an inpatient stay.

- **Retrospective Record Review** — The purpose of retrospective record review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of health care services. Our effort to manage the services provided to you includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Member Services

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

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

Privacy Notice

How we guard your privacy - We're committed to keeping your personal information safe

What personal information is and what it isn't - By "personal information," we mean that which can identify you. It can include financial and health information. It doesn't include what the public can easily see. For example, anyone can look at what your plan covers.

How we get information about you - We get information about you from many sources, including from you. But we also get information from your employer, other insurers, or health care providers like doctors.

When information is wrong - Do you think there's something wrong or missing in your personal information? You can ask us to change it. The law says we must do this in a timely way. If we disagree with your change, you can file an appeal. Information on how to file an appeal is on our member website. Or you can call the toll-free number on your ID card.

How we use this information - When the law allows us, we use your personal information both inside and outside our company. The law says we don't need to get your permission when we do.

We may use or share your protected health information (PHI):

- With the U.S. Office of Personnel Management (OPM)
- With your employing agency in connection with payment or health care operations
- When required by federal law

We're also required to share your PHI to OPM for its claims data warehouse. The data is used for its Federal Employees Health Benefits (FEHB) Program.

We may use it for your health care or use it to run our plans. We also may use your information when we pay claims or work with other insurers to pay claims. We may use it to make plan decisions, to do audits, or to study the quality of our work.

This means we may share your info with doctors, dentists, pharmacies, hospitals or other caregivers. We also may share it with other insurers, vendors, government offices, or third-party administrators. But by law, all these parties must keep your information private.

When we need your permission - There are times when we do need your permission to disclose personal information.

This is explained in our Notice of Privacy Practices. This notice clarifies how we use or disclose your Protected Health Information (PHI):

- For workers' compensation purposes
- As required by law

- About people who have died
- For organ donation
- To fulfill our obligations for individual access and HIPAA compliance and enforcement

You may ask for more information about our privacy practices (including receiving this notice in other languages) or request a member right by sending an email to the CVS Health Privacy Team at PrivacyOffice@cvshealth.com. Or call the toll-free number on your ID card.

If you want more information about us, call 888-238-6240, or write to Aetna, Federal Plans, PO Box 818047, Cleveland, OH 44181-8047. You may also contact us by fax at 860-975-1669 or visit our website at www. aetnafeds.com.

HDHP and Direct Plan Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our network providers practice. The enrollment code for all service areas is 22 and N6. Our service areas are:

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

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

Arizona - All of Arizona.

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

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

Colorado – All of Colorado.

Connecticut – All of Connecticut.

Delaware – All of Delaware.

District of Columbia – All of Washington, DC.

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

Georgia - All of Georgia

Hawaii - All of Hawaii.

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

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

Indiana - All of Indiana.

Iowa - All of Iowa.

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

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

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

Concordia - 71326, 71334, 71377

Maine – All of Maine.

Maryland – All of Maryland.

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

Michigan - All of Michigan.

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

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

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

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

Nebraska - All of Nebraska

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

New Hampshire – All of New Hampshire.

New Jersey – All of New Jersey.

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

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

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

North Carolina - All of North Carolina.

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

Ohio - All of Ohio.

Oklahoma - All of Oklahoma.

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

Pennsylvania - All of Pennsylvania.

Rhode Island - All of Rhode Island.

South Carolina - All of South Carolina.

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

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

Texas - All of Texas.

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

Vermont - All of Vermont.

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

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

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

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

Wisconsin - All of Wisconsin.

Wyoming - All of Wyoming.

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

Section 2. Changes for 2026

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

Changes to our Aetna Direct Plan

- Your share of the premium rate under the Aetna Direct Plan option will increase for Self Only, Self Plus One, and Self and Family. (See Rate Information)
- **Walk-in clinic -** The Plan will increase the cost share for care at a walk-in clinic or CVS MinuteClinic from $0 to 20% of our plan allowance for in-network services and 40% of plan allowance and any difference between our allowance and the billed amount for out-of-network . (See Section 5a).

Changes to our High Deductible Health Plan (HDHP)

- Your share of the premium rate under the High Deductible Health Plan (HDHP) option will increase for Self Only, increase for Self Plus One, and increase for Self and Family. (See Rate Information)
- **Calendar year deductible** – The Plan will increase the amount an individual needs to meet their calendar year deductible when covered under Self Plus One or Self and Family enrollment. The amount will increase from $3,300 to $3,400. The overall Self Plus One or Self and Family deductible for in-network and out-of-network is not changing. (See Section 5).
- **Walk-in clinic -** The Plan will increase the cost share for care at a walk-in clinic or CVS MinuteClinic from $0 to 15% of our plan allowance for in-network services and 40% of plan allowance and any difference between our allowance and the billed amount for out-of-network . (See Section 5a.)

Changes to Both High Deductible Health Plan (HDHP) and Aetna Direct Plan

- **Services that require plan approval (other services)** – The Plan updated its list of services that require plan approval. (See Section 3)
- **Infertility Services** - The Plan is removing cycle limits on Artificial Insemination, adding embryo, egg, and sperm storage for 1 year for individuals facing iatrogenic infertility and adding Advanced Reproductive Technology (including In Vitro Fertilization and Ovulation Induction) for up to 3 cycles per member per calendar year. (See Section 5a for additional details, cost share and benefit requirements.)
- **Infertility Medications -** The Plan is adding a $25,000 maximum per member per calendar year on infertility medications. (See Section 5f.)
- **Treatment for Gender Dysphoria** - The Plan is removing surgical or chemical regimen for Sex-Trait Modification for members diagnosed with gender dysphoria. (See Sections 5b. and 5f.)

Section 3. How You Get Care

Identification cards	We will send you an identification (ID) card when you enroll. If you enroll as Self Plus One or Self and Family, you will receive two Family ID cards. You should carry your ID card with you at all times. You must show it whenever you receive services from a Network provider or fill a prescription at a Network pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter. If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 888-238-6240 or write to us at Aetna, P.O. Box 14079, Lexington, KY 40512-4079. You may also request replacement cards through our Aetna Member website at www.aetnafeds.com.
Where you get covered care	You can get care from any licensed provider or licensed facility. How much we pay – and you pay – depends on whether you use a network or non-network provider or facility. If you use a non-network provider, you will pay more.
Balance Billing Protection	FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.
Network providers	Network providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Network providers according to national standards. Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area. We list Network providers in the provider directory, which we update periodically. The most current information on our Network providers is also on our website at www.aetnafeds.com. This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender. This plan provides Care Coordinators for complex conditions and can be reached at www.aetnafeds.com for assistance.
Network facilities	Network facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these facilities in the provider directory, which we update periodically. The most current information on our Network facilities is also on our website at www.aetnafeds.com.
Non-network providers and facilities	You can access care from any licensed provider or facility. Providers and facilities not in Aetna's networks are considered non-network providers and facilities.
What you must do to get covered care	It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance.
• **Transitional care**	**Specialty care**: You may continue seeing your specialist for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:

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

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

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

If you are mid-treatment under this plan, within a surgical or chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. You may be eligible for our continuation of care process only if the covered surgical or chemical regimen was initiated, with prior approval, before January 1, 2026. Please refer to www.aetnafeds.com/gender-affirming-care.php for additional details, forms and requirements regarding the continuation of care process. If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process.

Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.

- **Hospital care**

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

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

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

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

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

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

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

You need prior Plan approval for certain services

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

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

- **Inpatient hospital admission**

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

- **Other services**

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

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

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

- Inpatient confinements (except hospice) - For example, surgical and nonsurgical stays; stays in a skilled nursing facility or rehabilitation facility; and maternity and newborn stays that exceed the standard length of stay (LOS)
- Ambulance - Precertification required for transportation by fixed-wing aircraft (plane)
- Ankle arthroplasty (total)
- Autologous chondrocyte implantation
- Cardiology (implantable loop recorder, Watchman™, Electrophysiological (EP) study)
- Certain mental health services, inpatient admissions, Residential treatment center (RTC) admissions, Partial hospitalization programs (PHPs), Transcranial magnetic stimulation (TMS) and Applied Behavior Analysis (ABA)
- Chiari malformation decompression surgery
- Cochlear device and/or implantation
- Coverage at an in-network benefit level for out-of-network provider or facility unless services are emergent. Some plans have limited or no out-of-network benefits.
- Covered transplant surgery
- Dialysis visits -When request is initiated by a participating provider, and dialysis to be performed at a nonparticipating facility
- Dorsal column (lumbar) neurostimulators: trial or implantation
- Endoscopic nasal balloon dilation procedures
- Electric or motorized wheelchairs and scooters
- Functional endoscopic sinus surgery
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- Hyperthermic intraperitoneal chemotherapy (HIPEC)
- Infertility services and pre-implantation genetic testing
- Knee arthroscopy and meniscectomy
- Lower limb prosthetics, such as: Microprocessor controlled lower limb prosthetics
- Neurostimulator implantation
- Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)
- Osseointegrated implant
- Osteochondral allograft/knee

- Private duty nursing (see Home Health services)
- Prostate surgery (high intensity-focused ultrasound)
- Proton beam radiotherapy
- Reconstructive or other procedures that maybe considered cosmetic, such as:
  - Blepharoplasty/canthoplasty
  - Breast reconstruction/breast enlargement
  - Breast reduction/mammoplasty
  - Excision of excessive skin due to weight loss
  - Gastroplasty/gastric bypass
  - Lipectomy or excess fat removal
  - Surgery for varicose veins, except stab phlebectomy
- Shoulder arthroplasty
- Site of Service - when requested at an Outpatient hospital setting and when is one of the following:
  - Breast tissue excision
  - Complex wound repair
  - Cystourethroscopy
  - Septoplasty
  - Skin tissue transfer or rearrangement
  - Turbinate resection
  - Tympanostomy
- Spinal procedures, such as:
  - Artificial intervertebral disc surgery (cervical and lumbar spine)
  - Cervical laminoplasty
  - Cervical, lumbar and thoracic laminectomy/laminotomy procedures
  - Kyphectomy
  - Laminectomy with rhizotomy
  - Removal of spinal instrumentation
  - Sacroiliac joint fusions
  - Spinal fusion surgery
  - Surgery for spinal deformity
  - Vertebral corpectomy
  - Vertebroplasty/Kyphoplasty
- Stimulators (electrical stimulation device used for cancer treatment)
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices
- Whole exome sequencing
- Whole genome sequencing
- Drugs and medical injectables (including but not limited to blood clotting factors, botulinum toxin, alpha-1-proteinase inhibitor, palivizumab (Synagis), erythropoietin therapy, intravenous immunoglobulin, growth hormone and interferons when used for hepatitis C)*

- Special Programs (including but not limited to BRCA genetic testing, Chiropractic precertification, Diagnostic Cardiology (cardiac rhythm implantable devices, cardiac catheterization), Hip and knee arthroplasties, National Medical Excellence Program®, Pain management, Peripheral Aterial Disease, Polysomnography (attended sleep studies), Radiation oncology, Radiology imaging (such as CT scans, MRIs, MRAs, nuclear stress tests), Sleep Studies*

*For complete list refer to:

www.aetna.com/health-care-professionals/precertification/precertification-lists.html or the Behavioral Health Precertification list. The specialty medication precertification list can be found at: www.aetnafeds.com/pharmacy.php.

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

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

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

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

Next, provide the following information:

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

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

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

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

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

- **Non-urgent care claims**

For non-urgent care claims, we will 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 or not it is an urgent care claim by applying the judgment of a prudent layperson that 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 888-238-6240. You may also call OPM's FEHB 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 888-238-6240. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, 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 phone us within one (1) business day following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

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

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

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

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

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

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

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

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

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

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

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

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

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

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Cost for Covered Services

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

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	A copay is the fixed amount of money you pay to the pharmacy (e.g., when you receive generic drugs on our formulary
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. **HDHP** You must satisfy your deductible before your Traditional medical coverage begins. For the HDHP, your annual deductible is $1,800 for a Self Only enrollment, $3,600 for a Self Plus One enrollment and $3,600 for Self and Family enrollment in-network and $2,600 for a Self Only enrollment, $5,200 for a Self Plus One enrollment and $5,200 for a Self and Family enrollment out-of-network. Once an individual meets a $3,400 deductible under the Self Plus One or Self and Family enrollment, they will then be covered under Plan benefits. The remaining balance of the Self Plus One and Family deductible can be satisfied by one or more family members. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin. **Aetna Direct** You must satisfy your deductible before your Traditional medical coverage begins. For the Direct plan, your annual deductible is $1,600 for a Self Only enrollment, $3,200 for a Self Plus One enrollment and $3,200 for Self and Family enrollment in-network and $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment out-of-network. Once an individual meets the Self Only deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductibles for in-network and out-of-network do not cross apply and will need to be met separately for traditional benefits to begin. **(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible)** Note: If you change plans during Open Season, you do not have to start a new deductible under your prior plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your prior option to the deductible of your new option.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: You pay 15% of our Plan allowance for in-network durable medical equipment under the HDHP. Note: If you are enrolled in Aetna Direct and if you have Medicare Part A and B and it is primary, we will waive your coinsurance for most services.
Differences between our Plan allowance and the bill	Network Providers agree to accept our Plan allowance so if you use a network provider, you never have to worry about paying the difference between our Plan allowance and the billed amount for covered services. Non-Network Providers: If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount.

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

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

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

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

Your out-of-pocket maximum: $6,900/$13,800 in-network; $9,000/$18,000 out-of-network***

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

Hospital bill:

Amount billed In-network: $25,000

Amount billed Out-of-network: $25,000

Amount Aetna uses to calculate payment in-network rate*: $8,750

Amount Aetna uses to calculate payment Recognized amount** out of network: $8,750

What your Aetna plan will pay:

Negotiated/recognized amount for in-network and out of network: $8,750

What percent your Aetna plan will pay:

In-network: 85% of negotiated rate/ recognized amount covered under plan: $7,437.50

Out-of-network: 60% of negotiated rate/ recognized amount covered under plan: $5,250

What you owe:

In-network: Your coinsurance responsibility - 15%: $1,312.50

Out-of-network: Your coinsurance responsibility - 40%: $3500

Amount that can be balance billed to you:

In-network: $0

Out-of-network: $15,250

Your Total responsibility:

In-network: $1,312.50

Out-of-network: $19,750

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

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

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

You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

Out-of-pocket maximums are the amount of out-of-pocket expenses that a Self Only, a Self Plus One or a Self and Family will have to pay in a plan year. Out-of-pocket maximums apply on a calendar year basis only. Once an individual meets the Self Only out-of-pocket maximum under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical expenses at 100%. The remaining balance of the Self Plus One or Self and Family out-of-pocket maximum can be satisfied by one or more family members. 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. In-network and out-of-network out-of-pocket maximums do not cross apply and will need to be met separately in order for eligible medical expenses to be paid at 100%.

HDHP

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

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

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

Self Only:

In-network: Your annual out-of-pocket maximum is $6,900.

Out of-network: Your annual out-of-pocket maximum is $9,000.

Self Plus One:

In-network: Your annual out-of-pocket maximum is $13,800.

Out of-network: Your annual out-of-pocket maximum is $18,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is $13,800.

Out of-network: Your annual out-of-pocket maximum is $18,000.

Direct Plan

Only the deductible and those out-of-pocket expenses resulting from the application of coinsurance percentage (except any penalty amounts) and copayments may be used to satisfy the out-of-pocket maximums. Once an individual meets the Self Only out-of-pocket maximum under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical expenses at 100%. The remaining balance of the Self Plus One or Self and Family out-of-pocket maximum can be satisfied by one or more family members. If you are enrolled in our Aetna Medicare Rx – offered by SilverScript. You will have a separate $2,000 out of pocket maximum for your prescription costs. Once you reach this maximum you will no longer pay a cost share for covered drugs. This $2,000 will also apply to the Plan’s out-of-pocket maximum, see below for additional details.

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

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

Self Only:

In-network: Your annual out-of-pocket maximum is $6,000.

Out of-network: Your annual out-of-pocket maximum is $7,000.

Self Plus One:

In-network: Your annual out-of-pocket maximum is $12,000.

Out of-network: Your annual out-of-pocket maximum is $14,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is $12,000.

Out of-network: Your annual out-of-pocket maximum is $14,000.

The following cannot be included in the accumulation of out-of-pocket expenses for the HDHP or Aetna Direct:

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

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 prior 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 prior 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 prior 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 prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

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

When Government facilities bill us

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

Important Notice About Surprise Billing – Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.
A surprise bill is an unexpected bill you receive for:

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by certain nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the nonparticipating provider, facility, or air ambulance service for the difference between the nonparticipating provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills. Any claims subject to the No Surprises Act will be paid in accordance with the requirements of such law. Aetna will determine the rate payable to the out-of-network provider based on the median in-network rate or such other data resources or factors as determined by Aetna. Your cost share paid with respect to the items and services will be based on the qualifying payment amount, as defined under the No Surprises Act, and applied toward your in-network deductible (if you have one) and out-of-pocket maximum.

Please note: there are certain circumstances under the law where a provider can give you notice that they are out of network and you can consent to receiving a balance bill. For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.aetnafeds.com or contact the health plan at 888-238-6240.

The Federal Flexible Spending Account Program – *FSAFEDS*

- **Healthcare FSA (HCFSA)** – Reimburses an FSA participant for eligible out-of-pocket healthcare expenses (such as copayments, deductibles, over-the-counter drugs and medications, vision and dental expenses, and much more) for their tax dependents, and their adult children (through the end of the calendar year in which they turn 26).
- **FSAFEDS** offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Section 5. High Deductible Health Plan Benefits

See Section 2 for how our benefits changed this year and Summary of Benefits for a benefits summary.

Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this Section. Make sure that you review the benefits carefully.

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

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

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

With this Plan, in-network preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described in Section 5. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

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

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

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

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

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

  After you have paid the Plan's deductible (In-network: $1,800 for Self Only enrollment, $3,600 for Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-network: $2,600 for Self Only enrollment, $5,200 for Self Plus One enrollment and $5,200 for Self and Family enrollment), we pay benefits under Traditional medical coverage described in Section 5. The Plan typically pays 85% for in-network care and 60% for out-of-network care. Once an individual meets a $3,400 deductible under the Self Plus One or Self and Family enrollment, they will then be covered under Plan benefits. The remaining balance of the Self Plus One and Family deductible can be satisfied by one or more family members. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.

  Covered services include:

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

- Special features

- **Savings**

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (See Section 5. Savings – HSAs and HRAs for more details).

Health Savings Accounts (HSAs)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA (except for veterans with a service-connected disability) and/or Indian Health Service (IHS) benefits within the last three months, or do not have other health insurance coverage other than another High Deductible Health Plan. In 2026, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $66.67 per month for a Self Only enrollment or $133.34 per month for a Self Plus One or a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $4,400 for Self Only enrollment and $8,750 for Self Plus One or Self and Family enrollment. The IRS allows you to contribute up to $1,000 in additional contributions for 2026, if you are age 55 or older. See maximum contribution information in Section 5. Savings – HSAs and HRAs. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

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

HSA features include:

- Inspira Financial provides a debit card and record-keeping services. Inspira Financial is the custodian for the HSA accounts.
- Your contributions to the HSA are tax deductible.(State taxes apply in California, Alabama and New Jersey).
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest or any investment gains through a choice of voluntary investment options. (New Hampshire and Tennessee do tax dividends and earnings on HSA's)
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 and 969 for information on eligible expenses.) A link to this publication can also be found at www.aetnafeds.com.
- Your unused HSA funds and interest accumulate from year to year.
- It's portable – the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire.
- When you need it, funds up to the actual HSA balance are available.

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

Health Reimbursement Arrangements (HRA)

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

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

In 2026, we will give you an HRA credit of $800 per year for a Self Only enrollment, $1,600 for a Self Plus One enrollment and $1,600 per year for a Self and Family enrollment. Your HRA will be used to help pay for covered services that apply towards your health plan deductible and/or for certain qualified medical expenses that don't count toward the deductible. (See IRS publication 502 and 969 for information on qualified medical expenses).

HRA features include:

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

- **Biometric Screening with Incentive and Health Risk Assessment**

Biometric screening and health risk assessment incentive: (available February 1st - December 31st)
The Plan will provide an incentive to the Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) for an enrollee and/or spouse (over 18 years of age) who complete a biometric screening and the Plan's health assessment. Biometric screenings must include total cholesterol, HDL, calculated LDL, calculated cholesterol/HDL ratio, triglycerides and glucose, blood pressure, and waist circumference. Members obtain the screening at a Quest Diagnostics Patient Service Center (PSC). If you are not located within 20 miles of a Quest Diagnostics PSC, you may send the appropriate form to your physician's office and request that your physician complete the form and fax or mail it back to Quest. Visit www.aetnafeds.com for information on setting up an appointment at a Quest PSC or to obtain the form if you are not located within 20 miles of a Quest PSC.

The Plan will provide an incentive to the HSA or HRA of $75 per enrollee and/or spouse, up to an annual family limit of $150 upon completion of the biometric screening and health assessment.

Note: Additional deposits by the Plan into your HSA can impact the amount you can contribute for the year. Please review IRS guidelines or discuss with your accountant.

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

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $6,900 for Self Only, $13,800 for Self Plus One or $13,800 for Self and Family enrollment. If you use non-network providers, your out-of-pocket maximum is $9,000 for Self Only, $18,000 for Self Plus One or $18,000 for Self and Family enrollment. Once an individual meets the Self Only out-of-pocket maximum under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical expenses at 100%. The remaining balance of the Self Plus One or Self and Family out-of-pocket maximum can be satisfied by one or more family members. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details. In-network and out-of-network out-of-pocket maximums do not cross apply and will need to be met separately in order for eligible medical expenses to be paid at 100%.

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

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

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

- Perform self-service functions, like checking your HRA fund or HSA account balance and deductible balance or the status of a claim.

Aetna Member website gives you direct access to:

- Care and Costs tools that compare in-network and out-of-network provider fees, the cost of brand-name drugs vs. their generic equivalents, and the costs for services such as routine physicals, emergency room visits, lab tests, X-rays, MRIs, etc.
- Real-time, out-of-pocket estimates for medical expenses based on your Aetna health plan. You can compare the cost of doctors and facilities before you make an appointment, helping you budget for and manage health care expenses.
- A hospital comparison tool that allows you to see how hospitals in your area rank on measures important to your care.
- Our online provider directory.
- Online customer service that allows you to request member ID cards, send secure messages to Member Services, and more.
- Tools and resources to help you manage your health with access to your health assessment, digital coaching, personal health records, and more.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you with Inspira Financial (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). Aetna Life Insurance Company Federal Plans PO Box 818047 Cleveland, OH 44181-8047 888-238-6240 www.aetnafeds.com	Aetna Life Insurance Company is the HRA fiduciary for this Plan. Aetna Life Insurance Company Federal Plans PO Box 818047 Cleveland, OH 44181-8047 888-238-6240 www.aetnafeds.com
Fees	There is no HSA set-up fee. The administrative fee is covered in the premium while the member is covered under the HDHP. If you are no longer covered under the HDHP, there is a $5 monthly administrative fee that will be deducted from your HSA account every month. Members will be subject to the administrative fee if they are enrolled but no longer eligible for contributions and enrolled in the HRA.	None
Eligibility	You must: • Enroll in the Aetna HealthFund High Deductible Health Plan (HDHP) • Not currently receiving VA benefits or services except for veterans with a service-connected disability. • Have no other health insurance coverage (does not apply to another HDHP plan, specific injury, accident, disability, dental, vision, or long term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return • Not have received Indian Health Service (IHS) benefits in the last three months • Complete and return all banking paperwork	You must enroll in the Aetna HealthFund High Deductible Health Plan (HDHP). If you enroll in a HDHP during open season or in the month of January, your HRA will be funded up to the yearly maximum. If you enroll outside of open season or other than the month of January, the funding of your HRA will be prorated based on each full month in which you are enrolled in a HDHP.

Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. Note: If your effective date in the HDHP is after the 1st of the month, the earliest your HSA will be established is the 1st of the following month. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.). You may contribute to your HSA by setting up an electronic funds transfer from your checking or savings account up to the maximum allowed. The deadline for HSA contributions is April 15 following the year for which contributions are made. When making contributions for a previous tax year, use the correct tax year if you are adding your own deposits from a linked bank account. You can obtain additional HSA forms by logging into the Aetna Member website at www.aetnafeds.com.	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• **Self Only enrollment**	For 2026, a monthly premium pass through of $66.67 will be made by the HDHP directly into your HSA each month.	For 2026, your HRA annual credit is $800 (prorated for mid-year enrollment).
• **Self Plus One enrollment**	For 2026, a monthly premium pass through of $133.34 will be made by the HDHP directly into your HSA each month.	For 2026, your HRA annual credit is $1,600 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2026, a monthly premium pass through of $133.34 will be made by the HDHP directly into your HSA each month.	For 2026, your HRA annual credit is $1,600 (prorated for mid-year enrollment).
Contributions/ credits	The maximum that can be contributed to your HSA is an annual combination of the HDHP premium pass through, the Biometric screening and health risk assessment incentive and enrollee contribution funds, which when combined, do not exceed the annual statutory dollar maximum, which is $4,400 or Self Only coverage, $8,750 for Self Plus One coverage and $8,750 for Self and Family coverage for 2026. If you are age 55 or older, the IRS permits you to make additional contributions to your HSA. The allowable additional contribution is $1,000.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.

	Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the IRS website at www.irs.gov or request a copy of IRS Publication 969 by calling 1-800-829-3676. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. **Note: Annual premium pass through contributions will be forfeited if you do not open an HSA by 12/31 of that plan year.** You are eligible to fund your account up to the maximum contribution limit set by the IRS, even if you have partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). You are able to make a one-time, tax-free, irrevocable, trustee-to-trustee rollover from your IRA to your HSA. The amount that may be rolled over from an IRA to an HSA is limited to the amount of your maximum annual HSA contribution limit for the year in which the rollover is made. Any amount you rollover from an IRA will count towards your annual HSA contribution limit so you will need to make sure that the amount you transfer from your IRA combined with your other HSA contributions for the year do not exceed the annual HSA contribution limit. HSAs earn tax-free interest (does not affect your annual maximum contribution). Over age 55 additional contribution discussed below.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.

• **Self Only enrollment**	You may make a voluntary annual maximum contribution of $3,600. Note: Additional deposits by the Plan into your HSA can impact the amount you can contribute for the year. Please review IRS guidelines or discuss with your accountant.	You cannot contribute to the HRA.
• **Self Plus One enrollment**	You may make a voluntary annual maximum contribution of $7,150. Note: Additional deposits by the Plan into your HSA can impact the amount you can contribute for the year. Please review IRS guidelines or discuss with your accountant.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make a voluntary annual maximum contribution of $7,150. Note: Additional deposits by the Plan into your HSA can impact the amount you can contribute for the year. Please review IRS guidelines or discuss with your accountant.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit Card – The Debit Card must be activated in order to have access to HSA Funds, customer service and online information. • The online employee portal. • Connected Claims Option - Connected claims is a fast and easy way to pay out-of-pocket health expenses from your HSA. If you are a member of an Aetna HDHP and enrolled in an Aetna HSA you can elect to have your claims sent directly to your HSA to pay for qualified out-of-pocket expenses, paying the doctor directly, without having to use your Inspira Financial Aetna HSA MasterCard debit card. • Direct Deposit for HSA Reimbursement - Reimbursements can now be sent electronically to personal checking or savings accounts. You can access this feature from the employee portal.	For covered medical expenses under your HDHP, claims will be paid automatically by your HRA when claims are submitted to Aetna, if there is money available in your HRA.
Distributions/with-drawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. You must submit these expenses with a claim form (available on our website www.aetnafeds.com) for reimbursement.

	Your HSA is established the first of the month following the effective date of your enrollment in this HDHP. For most Federal enrollees (those not paid on a monthly basis), the HDHP becomes effective the first pay period in January 2026. If the HDHP is effective on a date other than the first of the month, the earliest date medical expenses will be allowable is the first of the next month. If you were covered under the HDHP in 2025 and remain enrolled in this HDHP, your medical expenses incurred January 1, 2026 or later, will be allowable. If you incur a medical expense between your HDHP effective date but before your HSA is effective, you will not be able to use your HSA to reimburse yourself for those expenses. Note: Plan contributions are typically deposited around the middle of each month. See IRS Publication 502 and 969, which you can access at www.aetnafeds.com, for information on eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.	See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 and 969, for a list of qualified eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: - Your enrollment in this HDHP is effective (effective date is determined by your agency in accordance with the event permitting the enrollment change). - The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. - The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you.	Funds are not available until: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The entire amount of your HRA will be available to you upon your enrollment in the HDHP. (The HRA amount will be pro rated based on the effective date of coverage.)

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

Fees for Federal Employees Health Benefits Program

Fee Description	Fee
Monthly Account Maintenance	**No charge**
Returned Deposit Check	**$25.00 per returned deposit check**
Checks Returned for Non-sufficient Funds	**$25.00 per returned check**
Stop Payment of Check	**$25.00 per stopped check**
Returned EFT Deposit*	**$25.00 per EFT deposit return**
Account Closing	**$25.00 per closure**
Replacement of Lost/Stolen HSA Debit Card	**No charge**
Paper Statement	**$1.50 - available online at no charge**
Investment Fee	**You can open an investment account and you will be charged monthly at .03% of your investment account balance.**
Trustee Transfer Fee	**$25.00 per transfer**

*Electronic Funds Transfer (EFT)

If you have an HSA

- **Contributions**

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

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

- **Over age 55 additional contributions**

If you are age 55 or older, the IRS permits you to make additional contributions to your HSA. The allowable catch-up over age 55 additional contribution is $1,000 in 2026 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the IRS website at www.irs.gov or request a copy of IRS Publication 969 by calling 1-800-829-3676.

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

- **If you die**

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

- **Investment Options**

Participation in voluntary investment options is entirely optional and neither Aetna nor Inspira Financial is or will be acting in the capacity of a registered investment advisor.

Account holders who exceed the minimum required balance of $1,000 in their HSA cash account, will have a number of different investment options to choose from in 2026 that will be offered by different organizations that have been selected by Inspira Financial Balances in these investment options may fluctuate up or down and will not be insured by the FDIC or other government agencies.

Inspira Financial will make available HSA investment options, as defined below, to account holders who exceed the minimum required balance of $1,000 in their HSA cash account. (Investment options are subject to change).

These funds are distributed through BNY Mellon and are not offered or insured by Inspira Financial or BNY Mellon. Participation in these options will be entirely optional, and neither Inspira Financial or BNY Mellon is or will be acting in the capacity of a registered investment advisor with respect to these options. Balances in the funds may fluctuate and will not be insured by the FDIC or other government agency.

Equity funds

- JPMorgan Large Cap Growth Fund - Select Class
- Schwab Fundamental US Large Company Index Fund
- Davis New York Venture Fund Class Y
- Vanguard 500 Index Admiral
- Vanguard Dividend Appreciation Index Admiral

- Invesco-Oppenheimer Main St Fund® CIY
- Parnassas Mid Cap Fund Institutional Shares
- American Century Investments® Mid Cap Value Fund Class 1
- Artisan Small Cap Fund Institutional Shares
- Vanguard Small-Cap Index Admiral
- Dodge & Cox International Stock Fund
- Thornburg International Value Fund Class I
- Vanguard Developed Markets Index Admiral
- Vanguard Emerging Markets Stock Index Admiral

Bond Funds

- American Funds Inflation Linked Bond R6
- BlackRock Strategic Income Opportunities Institutional
- Dodge & Cox Income Fund
- MetWest Total Return Bond Fund Class M

Other Funds

- American Funds 2020 Target Date Retire R6
- American Funds 2025 Target Date Retire R6
- American Funds 2030 Target Date Retire R6
- American Funds 2035 Target Date Retire R6
- American Funds 2040 Target Date Retire R6
- American Funds 2045 Target Date Retire R6
- American Funds 2050 Target Date Retire R6
- American Funds 2055 Target Date Retire R6
- American Funds 2060 Target Date Retire R6
- Vanguard LifeStrategy Conservative Growth Investor
- Vanguard LifeStrategy Moderate Growth Investor

- **Qualified expenses**

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

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

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

- **Non-qualified expenses**

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

- **Tracking your HSA balance** — You can view account activity such as the "premium pass through," withdrawals, and interest earned on your account, as well as account balances online on the Aetna Member website. You can also request a paper monthly activity statement at an additional charge - $1.50 per month.
- **Minimum reimbursements from your HSA** — There is no minimum withdrawal or distribution amount.

If you have an HRA

- **Why an HRA is established** — If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you are or become ineligible to contribute to an HSA.
- **How an HRA differs** — Please review the chart beginning in Section 5. Savings – HSAs and HRAs which details the differences between an HRA and HSA. The major differences are:
  - you cannot make contributions to an HRA
  - funds are forfeited if you leave the HDHP
  - an HRA does not earn interest
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Medical and Dental Preventive Care

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

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

Benefit Description	You pay	
Medical Preventive Care, adult	**HSA**	**HRA**
• Routine physicals - one (1) exam every calendar year The following preventive services are covered at the time interval recommended at each of the links below. • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at: https ://www. uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at www. hrsa.gov/womens-guidelines • Adult Immunizations endorsed by the Centers for Disease Control and Prevention (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. For a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at www. cdc.gov/vaccines/imz-schedules/index.html	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay	
Medical Preventive Care, adult (cont.)	**HSA**	**HRA**
• To build your personalized list of preventive services go to https://health.gov/myhealthfinder.	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, limited to 26 visits per person per calendar year • Counseling programs when medically identified to support obesity prevention and management by an in-network provider Note: When anti-obesity medications is prescribed, see Section 5(f). Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b).	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (See Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (See Section 5), and the deductible.
Routine mammogram • One (1) every calendar year; or when medically necessary	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (See Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (See Section 5), and the deductible.
• The following exams and eyewear limited to: - One (1) routine eye exam every 12 months - One (1) routine hearing exam every 24 months	In-network: Nothing at a network provider.	In-network: Nothing at a network provider.

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay	
Medical Preventive Care, adult (cont.)	**HSA**	**HRA**
Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 888-238-6240 for information on whether a specific test is considered routine. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (See Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (See Section 5), and the deductible.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance license, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Medical Preventive Care, children	**HSA**	**HRA**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at www.cdc.gov/vaccines/imz-schedules/index.html • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-recommendations • To build your personalized list of preventive services go to https://health.gov/myhealthfinder • Well-child care charges for routine examinations, immunizations and care (up to age 22) - Seven (7) routine exams from birth to age 12 months - Three (3) routine exams from age 12 months to 24 months - Three (3) routine exams from age 24 months to 36 months - One (1) routine exam per year thereafter to age 22 • Hearing loss screening of newborns provided by a participating hospital before discharge • One (1) routine eye exam every 12 months through age 17 to determine the need for vision correction	In-network: Nothing at a network provider Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.

Medical Preventive Care, children - continued on next page

Benefit Description	You pay	
Medical Preventive Care, children (cont.)	**HSA**	**HRA**
• One (1) routine hearing exam every 24 months through age 17 to determine the need for hearing correction Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 888-238-6240 for information on whether a specific test is considered routine. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing at a network provider Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to comprehensive, intensive nutrition and behavioral weight-loss therapy and counseling programs under the USPSTF A and B recommendations. These programs are covered as part of prevention and treatment of obesity as follows: • Comprehensive, intensive nutrition and behavioral weight-loss counseling therapy Note: When anti-obesity medication is prescribed, see Section 5 (f). Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity, see Section 5(b).	In-network: Nothing at a network provider Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.
Not covered: • *Physical exams, required for obtaining or continuing employment or insurance, license, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters and medications for travel or work-related exposure*	*All charges*	*All charges*
Dental Preventive Care	**HSA**	**HRA**
Preventive care limited to: • Prophylaxis (cleaning of teeth – limited to two (2) treatments per calendar year) • Fluoride applications (limited to one (1) treatment per calendar year for children under age 16) • Sealants – (once every three (3) years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing X-rays (one (1) set per calendar year)	In-network: Nothing at a network dentist Out-of-network: All charges	In-network: Nothing at a network dentist Out-of-network: All charges

Dental Preventive Care - continued on next page

Benefit Description	You pay	
Dental Preventive Care (cont.)	**HSA**	**HRA**
• Complete series X-rays (one complete series every three (3) years) • Periapical X-rays • Routine oral evaluations (limited to two (2) per calendar year) Note: Participating network PPO dentists may offer members services at discounted fees. Discounts may not apply in all states. So, you may be charged less for your dental care when you visit a participating network PPO dentist. Refer to our online provider directory at www.aetnafeds.com to find a participating network PPO dentist, or call Member Services at 888-238-6240.	In-network: Nothing at a network dentist Out-of-network: All charges	In-network: Nothing at a network dentist Out-of-network: All charges
Not covered: We offer no other dental benefits other than those shown above.	*All charges*	*All charges*

Section 5. Traditional Medical Coverage Subject to the Deductible

Important things you should keep in mind about these benefits:

- Traditional medical coverage does not begin to pay until you have satisfied your deductible.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network medical and dental preventive care is covered at 100% (See Section 5. Medical and Dental Preventive Care) and is not subject to your calendar year deductible.
- The deductible is: In-network - $1,800 for Self Only enrollment, $3,600 for Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-Network - $2,600 per Self Only, $5,200 for Self Plus One enrollment or $5,200 per Self and Family enrollment. You must satisfy your deductible before your Traditional medical coverage may begin. Once an individual meets a $3,400 deductible under the Self Plus One or Self and Family enrollment, they will then be covered under Plan benefits. The remaining balance of the Self Plus One and Family deductible can be satisfied by one or more family members. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
- Under Traditional medical coverage, in-network benefits apply only when you use a network provider. Out-of-network benefits apply when you do not use a network provider. Your dollars will generally go further when you use network providers because network providers agree to discount their fees.
- Whether you use network or non-network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total $6,900 in-network and $9,000 out-of-network per Self Only enrollment, $13,800 in-network and $18,000 out-of-network per Self Plus One enrollment or $13,800 in-network and $18,000 out-of-network per Self and Family enrollment in any calendar year, you do not have to pay any more for covered services from network or non-network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Deductible before Traditional medical coverage begins	**HSA**	**HRA**
You must satisfy your deductible before your Traditional medical coverage begins. The Self, Self Plus One and Self and Family deductible can be satisfied by one or more family members. Once your Traditional medical coverage begins, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions, until you reach the annual catastrophic protection out-of-pocket maximum. At that point, we pay eligible medical expenses for the remainder of the calendar year at 100%. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.	100% of allowable charges until you meet the deductible: In-network: $1,800 for Self Only enrollment, $3,600 for Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-Network: $2,600 per Self Only enrollment, $5,200 for Self Plus One enrollment or $5,200 per Self and Family enrollment. You can use your HSA to help satisfy your deductible.	100% of allowable charges until you meet the deductible: In-network: $1,800 for Self Only enrollment, $3,600 for Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-Network: $2,600 per Self Only enrollment, $5,200 for Self Plus One enrollment or $5,200 per Self and Family enrollment. Your HRA Fund counts towards your deductible. Your HRA fund ($800/$1,600) is used first. Then you must pay the remainder of the deductible (e.g. In-network $1,600/$3,200) out-of-pocket i.e., $800/$1,600.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - $1,800 for Self Only enrollment, $3,600 for Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-Network - $2,600 for Self Only enrollment, $5,200 for Self Plus One enrollment and $5,200 for Self and Family enrollment each calendar year. The deductible applies to all benefits in this Section. Once an individual meets a $3,400 deductible under the Self Plus One or Self and Family enrollment, they will then be covered under Plan benefits. The remaining balance of the Self Plus One and Family deductible can be satisfied by one or more family members. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay After the calendar year deductible…
Diagnostic and treatment services	**HDHP**
Professional services of physicians • In physician's office - Office medical evaluations, examinations and consultations - Second surgical or medical opinion - Initial examination of a newborn child • In an urgent care center • During a hospital stay • In a skilled nursing facility • At home • Walk-In Clinic	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Telehealth services	**HDHP**
• Teladoc Health consult	In-network: 15% of the consult fee Out-of-network: No benefit. Must use Teladoc Health provider.
• CVS Health Virtual Care™ consult	In-network: $55 per consult until the deductible is met, $0 per consult after deductible has been met Out-of-network: Not available

Telehealth services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Telehealth services (cont.)	**HDHP**
Please see www. aetnafeds.com/tools.php for information on medical and behavioral telehealth services. Members will receive a welcome kit explaining the telehealth benefits. Refer to Section 5(e) for behavioral health telehealth consults.	Not applicable.
Lab, X-ray and other diagnostic tests	**HDHP**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CT Scans/MRI* • Ultrasound • Electrocardiogram and electroencephalogram (EEG) *Note: CT Scans and MRIs require precertification see Section 3 "Other Services" under "You need prior Plan approval for certain services."	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Genetic Counseling and Evaluation for BRCA Testing • Genetic Testing for BRCA-Related Cancer* *Note: Requires precertification. See "Services requiring our prior approval" in Section 3.	In-network: Nothing at a network provider Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Maternity care	**HDHP**
Complete maternity (obstetrical) care, such as: • Routine 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 and counseling for prenatal and postpartum depression Note: Items not considered routine include (but not limited to): - Amniocentesis - Certain Pregnancy diagnostic lab tests - Delivery including Anesthesia - Fetal Stress Tests - High Risk Specialist Visits - Inpatient admissions - Ultrasounds • Screening for gestational diabetes	In-network: No coinsurance for routine prenatal care or the first postpartum care visit when services are rendered by an in-network delivering health care provider, 15% of our Plan allowance for postpartum care visits thereafter. Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	**HDHP**
• Delivery • Postnatal care Notes: • You do not need to precertify your vaginal delivery; see below for circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. To enroll in the Enhanced Maternity program, call toll-free 1-800-272-3531. • You may remain in the hospital up to three (3) days after a vaginal delivery and five (5) days after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • Hospital Services are covered in Section 5(c) and Surgical Services are covered in Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits	In-network: No coinsurance for routine prenatal care or the first postpartum care visit when services are rendered by an in-network delivering health care provider, 15% of our Plan allowance for postpartum care visits thereafter. Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Breastfeeding and lactation support, supplies and counseling for each birth	In-network: Nothing at a network provider Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Home births	*All charges*
Family planning	**HDHP**
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Contraceptive counseling on an annual basis • Surgically implanted contraceptives • Generic injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms	In-network: Nothing Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible…
Family planning (cont.)	**HDHP**
Note: See additional Family Planning and Prescription drug coverage Section 5(f). Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. Visit www. AetnaFeds.com/FamilyPlanning.php for more information on contraception and the exception process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Note: We cover injectable contraceptives under the medical benefit when supplied by and administered at the provider's office. Injectable contraceptives are covered at the prescription drug benefit when they are dispensed at the Pharmacy. If a member must obtain the drug at the pharmacy and bring it to the provider's office to be administered, the member would be responsible for both the Rx and office visit cost shares. We cover oral contraceptives under the prescription drug benefit.	In-network: Nothing Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Voluntary male sterilization (See Section 5(b) Surgical procedures)	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*
Infertility services	**HDHP**
Infertility is a disease defined as when a person is unable to conceive or produce conception after one year of egg-sperm contact when the individual attempting conception is under 35 years of age, or after six months of egg-sperm contact when the individual attempting conception is 35 years of age or older. Egg-sperm contact can be achieved by regular sexual intercourse or artificial insemination (intrauterine, intracervical, or intravaginal) as stated in our medical clinical policy bulletin (See Section 10. for definition of Medical Necessity for additional details on Aetna's Clinical Policy). This definition applies to all individuals regardless of sexual orientation or the presence/availability of a reproductive partner. Infertility may also be established by the demonstration of a disease or condition of the reproductive tract such that egg-sperm contact would be ineffective. Diagnosis and treatment of infertility such as: • Testing for diagnosis and surgical treatment of the underlying medical cause of infertility.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission then facility charges will apply. See Section 5(c) for applicable facility charges.

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**HDHP**
Artificial insemination (AI)* ** • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI)	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission then facility charges will apply. See Section 5(c) for applicable facility charges.
Advanced Reproductive Technologies (ART):* ** (Combined limit of 3 cycles of Ovulation Induction and In vitro fertilization (IVF) per calendar year). • Ovulation Induction • Egg retrieval and fertilization • Intracytoplasmic sperm injection (ICSI) • Embryo transfer We limit Ovulation Induction and In Vitro Fertilization (IVF) to 3 cycles per calendar year. The Plan defines a “cycle” as: • Ovulation induction cycle(s) while on injectable medication (including but not limited to menotropins, hCG, GnRH) to stimulate the ovaries. *(See Section 5(f) for coverage) • Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician * • Injectable fertility drugs including but not limited to menotropins, hCG, and GnRH agonists. (See Section 5(f) for coverage)* You are eligible for covered ovulation induction medication cycles if: • You or your partner have been diagnosed with infertility. • You have met the requirement for the number of months trying to conceive through egg and sperm contact. • Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna’s infertility clinical policy You are eligible for IVF if you meet our medical necessity criteria, which includes: • Natural or artificial insemination would not be expected to be effective, and ART would be expected to be the only effective treatment OR	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission then facility charges will apply. See Section 5(c) for applicable facility charges.

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**HDHP**
• You have met the requirement for the number of months trying to conceive through egg and sperm contact (For women under 35 years of age, an appropriate trial of egg-sperm contact requires 12 months of regular intravaginal inseminations or 4 cycles of timed intrauterine or intracervical inseminations, documented in the medical record. For women 35 years of age and older, an appropriate trial of egg-sperm contact requires 6 months of regular intravaginal inseminations or 3 cycles of timed intrauterine or intracervical insemination, documented in the medical record); • You have met the requirement for trying to conceive through ovulation induction (3 cycles for women 37 years of age or younger); AND • You or your partner have not gone through voluntary sterilization with or without reversal; AND • Your unmedicated day three (3) Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's Clinical Policy Bulletin (CPB) for Infertility. Note: The Plan does not cover infertility drugs under the medical benefit. See Section 5(f) for coverage.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission then facility charges will apply. See Section 5(c) for applicable facility charges.
Iatrogenic Infertility* ** • Fertility preservation procedures (retrieval of and freezing of eggs or sperm) for members facing iatrogenic infertility caused by chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or ovary or testicle removal for treatment of disease. • Storage of Embryo(s), Egg(s), Sperm for one year for members facing iatrogenic infertility. * ** Note: Storage costs are only covered for members who have undergone an approved fertility preservation procedure while covered under the Plan.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission then facility charges will apply. See Section 5(c) for applicable facility charges.
Aetna's National Infertility Unit Our NIU is here to help you and is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with understanding your benefits and the medical precertification process. You can learn more at www. AetnaInfertilityCare.com or call the NIU at 1-800-575-5999 (TTY: 711). * Subject to medical necessity ** Note: Requires Precertification. See Section 3 "Other Services" under "You need prior Plan approval for certain services." 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 888-238-6240. Your network provider will request approval from us in advance for your infertility services. If your provider is not a network provider, you are responsible to request approval from us in advance.	Not applicable.
Not covered:	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**HDHP**
• *All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle (except for those medically necessary services as stated above). These include, but are not limited to:* - *Imaging, laboratory services, and professional services* - *In vitro fertilization (IVF)* - *Zygote intrafallopian transfer (ZIFT)* - *Gamete intrafallopian transfer (GIFT)* - *Cryopreserved embryo transfers* - *Gestational carrier cycles* - *Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).* • *Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue (unless noted as covered)* • *All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father* • *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 ART procedures except as stated above* • *Services and supplies related to the above mentioned services, including sperm processing* • *Services associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g. office, hospital, ultrasounds, laboratory tests etc. (unless noted in covered section of iatrogenic infertility)* • *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. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization* • *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* • *Elective fertility preservation, such as egg freezing sought due to natural aging* • *Infertility treatments such as in vitro fertilization that might be needed after the necessary medical intervention*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**HDHP**
• *Storage costs (except for one year of storage as noted in covered section of iatrogenic infertility)* • *Obtaining sperm from a person not covered under this plan* • *Infertility treatment when a successful pregnancy could have been obtained through less costly treatment* (unless medical necessity is met for infertility benefits) • *Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause)as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy* • *Oral and Injectable infertility medication, See Section 5f* • *Any infertility service rendered that requires precertification without a prior authorization* • *Coverage for services received by a spouse or partner who is not a covered member under the plan*	*All charges*
Allergy care	**HDHP**
• Testing and treatment • Allergy injections • Allergy serum	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	**HDHP**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/ Tissue Transplants in Section 5(b). • Respiratory and inhalation therapy • Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy in a doctor's office or facility (For IV infusion and antibiotic treatment at home, see Home Health Services.) • Growth hormone therapy (GHT) Note: We cover growth hormone injectables under the prescription drug benefit.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission or an outpatient visit, then facility charges will apply. See Section 5(c) for applicable facility charges.

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	**HDHP**
Note: We will only cover GHT when we preauthorize the treatment. Call 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 Section 3 "Other Services" under "You need prior Plan approval for certain services." Note: Applied Behavior Analysis (ABA) – Children with autism spectrum disorder is covered under mental health. (See Section 5(e) for benefits)	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission or an outpatient visit, then facility charges will apply. See Section 5(c) for applicable facility charges.
Physical and occupational therapies	**HDHP**
60 visits per person, per calendar year for physical or occupational therapy, or a combination of both for the services of each of the following: • Qualified Physical therapists • Occupational therapists Note: We only cover therapy when a physician • Orders the care • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed. Note: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient therapy is covered under Hospital/Extended Care Benefits. • Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome Note: Physical therapy treatment of lymphedemas following breast reconstruction surgery is covered under the Reconstructive surgery benefit - See Section 5(b).	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission or an outpatient visit, then facility charges will apply. See Section 5(c) for applicable facility charges.
Not covered: • *Long-term rehabilitative therapy*	*All charges*
Pulmonary and cardiac rehabilitation	**HDHP**
• 20 visits per condition per member per calendar year for pulmonary rehabilitation to treat functional pulmonary disability. • Cardiac rehabilitation following qualifying event/condition is provided for up to 3 visits a week for a total of 18 visits.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Long-term rehabilitative therapy	*All charges*

Benefit Description	You pay After the calendar year deductible…
Habilitative Services	**HDHP**
Habilitative services for congenital or genetic birth defects including, but not limited to, autism or an autism spectrum disorder, and developmental delays. Treatment is provided to enhance the ability to function. Services include occupational therapy, physical therapy and speech therapy.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Speech therapy	**HDHP**
• 60 visits per person, per calendar year.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Hearing services (testing, treatment, and supplies)	**HDHP**
• Hearing exams for children through age 17 (*as shown in Preventive Care, children*) • One hearing exam every 24 months for adults (see In-Network Medical Preventive Care, adult) • Audiological testing and medically necessary treatments for hearing problems. Note: Discounts on hearing exams, hearing services, and hearing aids are also available. Please see the Non-FEHB Benefits section of this brochure for more information.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *All other hearing testing and services that are not shown as covered* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	**HDHP**
• Treatment of eye diseases and injury	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• One (1) routine eye exam (including refraction) every 12-month period (See In-Network Medical Preventive Care)	In-network: Nothing Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Corrective eyeglasses and frames or contact lenses (hard or soft) 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 15%.	85% of charges after $100
Not covered: • *Fitting of contact lenses*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Vision services (testing, treatment, and supplies) (cont.)	**HDHP**
• *Vision therapy, including eye patches and eye exercises, e.g., orthoptics, pleoptics, for the treatment of conditions related to learning disabilities or developmental delays* • *Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors*	*All charges*
Foot care	**HDHP**
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (except for surgical treatment)* • *Foot orthotics* • *Podiatric shoe inserts*	*All charges*
Orthopedic and prosthetic devices	**HDHP**
• Orthopedic devices such as braces and corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and prosthetic devices such as artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), penile implants, defibrillator and surgically implanted breast implant following mastectomy, and lenses following cataract removal. See Section 5(b) for coverage of the surgery to insert the device. • Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.) Note: Certain devices require precertification by you or your physician. Please see Section 3 for a list of services that require precertification.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Hair prosthesis prescribed by a physician for hair loss resulting from radiation therapy, chemotherapy or certain other injuries, diseases, or treatment of a disease. Note: Plan lifetime maximum of $500.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Orthopedic and corrective shoes not attached to a covered brace* • *Arch supports* • *Foot orthotics*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	**HDHP**
• *Heel pads and heel cups* • *Podiatric shoe inserts* • *Lumbosacral supports* • *All charges over $500 for hair prosthesis*	*All charges*
Durable medical equipment (DME)	**HDHP**
We cover rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Contact Plan at 888-238-6240 for specific covered DME. Some covered items include: • Oxygen • Dialysis equipment • Hospital beds (Clinitron and electric beds must be preauthorized) • Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Insulin pumps and related supplies such as needles and catheters • Certain bathroom equipment such as bathtub seats, benches and lifts • Medical foods taken for the treatment of Inborn Errors of Metabolism when provided by a participating DME provider and administered under the direction of a physician Note: Some DME may require precertification by you or your physician.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Home modifications such as stair glides, elevators and wheelchair ramps* • *Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities* • *Elastic stockings and support hose* • *Medical foods that do not require a prescription under Federal law even if your physician or other health care professional prescribes them* • *Nutritional supplements that are not administered by catheter or nasogastric tubes, except for oral medical foods taken for the treatment of Inborn Errors of Metabolism when administered under the direction of a physician* • *Replacement of durable medical equipment, prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's condition.*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Home health services	**HDHP**
• Home health services ordered by your attending physician and provided by nurses and home health aides through a home health care agency. Home health services include skilled nursing services provided by a licensed nursing professional; services provided by a physical therapist, occupational therapist, or speech therapist; and services of a home health aide when provided in support of the skilled home health services. Home health services are limited to one (1) visit per day with each visit equal to a period of four (4) hours or less. The Plan will allow up to 60 visits per member per calendar year. Your attending physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy. Note: Skilled nursing under Home health services must be precertified by your attending Physician.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Intravenous (IV) Infusion Therapy and medications	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Nursing care for the convenience of the patient or the patient's family* • *Transportation* • *Custodial care, i.e., home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative and appropriate for the active treatment of a condition, illness, disease, or injury* • *Services of a social worker* • *Services provided by a family member or resident in the member's home* • *Services rendered at any site other than the member's home* • *Services rendered when the member is not homebound because of illness or injury* • *Private duty nursing services*	*All charges*
Chiropractic	**HDHP**
No benefits	*All charges*
Alternative medicine treatments	**HDHP**
Acupuncture - 10 visits per member per calendar year (when considered medically necessary) Note: See Section 5(b) for our coverage of acupuncture when provided as anesthesia for covered surgery. See Section 5 Non-FEHB Benefits Available to Plan members for discount arrangements.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Other alternative medical treatments including but not limited to:	*All charges*

Alternative medicine treatments - continued on next page

Benefit Description	You pay After the calendar year deductible…
Alternative medicine treatments (cont.)	**HDHP**
• *Acupuncture other than stated above* • *Applied kinesiology* • *Aromatherapy* • *Biofeedback* • *Craniosacral therapy* • *Hair analysis* • *Reflexology*	*All charges*
Educational classes and programs	**HDHP**
Aetna offers disease management. Included are programs for: • Asthma • Cerebrovascular disease • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Coronary artery disease • Cystic Fibrosis • Depression • Diabetes • Hepatitis • Inflammatory bowel disease • Kidney failure • Low back pain • Sickle cell disease To request more information on our disease management programs, call 888-238-6240.	Nothing
Coverage is provided for: • Tobacco cessation programs, including individual group/phone counseling, and for physician prescribed over the counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence. Note: OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	In-network: Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat nicotine dependence. Out-of-network: Nothing up to our Plan allowance for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing up to our Plan allowance for OTC drugs and prescription drugs approved by the FDA to treat nicotine dependence.

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- 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).

Note: Equipment charges for medically necessary intraoperative neurological monitoring (IONM) services furnished in connection with a covered surgery are included in the benefit that the Plan issues to the approved surgical facility. The Plan will not pay IONM equipment charges (known as the “technical component”) billed by any other entity. If you are planning a surgery with a non-network surgeon who suggests using a non-participating IONM provider during the procedure, you should confirm that the good faith cost estimate the non-network surgeon furnishes you as required by law does not make you responsible for paying IONM equipment charges billed by a provider other than that approved facility.

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - $1,800 for Self Only enrollment, $3,600 for Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-Network - $2,600 for Self Only enrollment, $5,200 for Self Plus One enrollment and $5,200 for Self and Family enrollment each calendar year. The deductible applies to all benefits in this Section. Once an individual meets a $3,400 deductible under the Self Plus One or Self and Family enrollment, they will then be covered under Plan benefits. The remaining balance of the Self Plus One and Family deductible can be satisfied by one or more family members. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	**HDHP**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine 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)	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**HDHP**
• Surgical treatment of severe 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, nonalcoholic steatohepatitis (NASH) or refractory hypertension).* ** - Members must have attempted weight loss in the past without successful long-term weight reduction; and Members must have participated in and been compliant with an intensive multicomponent behavioral intervention through a combination of dietary changes and increased physical activity for 12 or more sessions occurring within two (2) years prior to surgery. Blood glucose control must be optimized, and psychological clearance may be necessary. **We will consider:** • Open or laparoscopic Roux-en-Y gastric bypass; or • Open or laparoscopic biliopancreatic diversion with or without duodenal switch; or • Sleeve gastrectomy; or • Laparoscopic adjustable silicone gastric banding (Lap-Band) procedures. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization for men (e.g., vasectomy) • Treatment of burns • Skin grafting and tissue implants	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
* Requires Precertification. See Section 3 “Other Services” under “You need prior Plan approval for certain services.” 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 888-238-6240. **Subject to medical necessity based on our clinical policy bulletin.	Not applicable.
Voluntary sterilization for women (e.g., tubal ligation)	Nothing (no deductible)
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 Section 5(a) Foot care)*	*All charges*

<table>
<tr><th>Benefit Description</th><th>You pay
After the calendar year deductible…</th></tr>
<tr><td>Reconstructive surgery</td><td>HDHP</td></tr>
<tr><td>• 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.</td><td>In-network: 15% of our Plan allowance

Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</td></tr>
<tr><td>Not covered:
• Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form and for which the disfigurement is not associated with functional impairment, except repair of accidental injury (See Section 5(d) Accidental injury).
• Surgery for Sex-Trait Modification to treat gender dysphoria

If you are mid-treatment under this plan, within a surgical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. You may be eligible for our continuation of care process only if the covered surgical regimen was initiated, with prior approval, before January 1, 2026. Please refer to www.aetnafeds.com/gender-affirming-care.php for additional details, forms and requirements regarding the continuation of care process. If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process.

Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.</td><td>All charges</td></tr>
</table>

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

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP**
Blood or marrow stem cell transplants Physicians measure many features of leukemia or lymphoma cells to gain insight into its aggressiveness or likelihood of response to various therapies. Some of these include the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. These analyses may allow physicians to determine which diseases will respond to chemotherapy or which ones will not respond to chemotherapy and may rather respond to transplant. The Plan extends coverage for the diagnoses as indicated below. • 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) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)* - Hemoglobinopathies - Hematopoietic Stem Cell Transplant (HSCT) - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders (i.e. Fanconi’s, Paroxysmal Nocturnal Hemoglobinuria, 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	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP**
- Breast Cancer* - Ependymoblastoma - Epithelial ovarian cancer* - Ewing's sarcoma - Hematopoietic Stem Cell Transplant (HSCT) - Multiple myeloma - Medulloblastoma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors - Waldenstrom's macroglobulinemia *Approved clinical trial necessary for coverage.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence. 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 • Non-myeloablative allogeneic, reduced intensity conditioning or RIC for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP**
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell anemia • Autologous Transplants for: - Advanced childhood kidney cancers - 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 lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive) - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP**
• **National Transplant Program (NTP) -** Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your primary care doctor and plan specialist physician and approved by our medical director in advance of the surgery. To receive in-network benefits the transplant must be performed at hospitals (Institutes of Excellence) specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program. *Note: Transplants must be performed at hospitals designated as Institutes of Excellence (IOE). Hospitals in our network, but not designated as IOE hospitals will be covered at the out-of-network benefit level. 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 (1) 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 (2) 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	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**HDHP**
c. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national cooperative body (e.g., Department of Defense, VA Affairs) and conforms to the rigorous independent oversight criteria as defined by the NCI for the performance of clinical trials; and d. The clinical trial is not a single institution or investigator study (NCI designated Cancer Centers are exempt from this requirement); and 4. The member must: a. Not be treated “off protocol,” and b. Must actually be enrolled in the trial.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials. Terminal illness means a medical prognosis of 6 months or less to live); and* • *Costs of data collection and record keeping that would not be required but for the clinical trial; and* • *Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs"); and* • *Items and services provided by the trial sponsor without charge* • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**HDHP**
Professional services (including Acupuncture - when provided as anesthesia for a covered surgery) provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- 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).

Note: Equipment charges for medically necessary intraoperative neurological monitoring (IONM) services furnished in connection with a covered surgery are included in the benefit that the Plan issues to the approved surgical facility. The Plan will not pay IONM equipment charges (known as the "technical component") billed by any other entity. If you are planning a surgery with a non-network surgeon who suggests using a non-participating IONM provider during the procedure, you should confirm that the good faith cost estimate the non-network surgeon furnishes you as required by law does not make you responsible for paying IONM equipment charges billed by a provider other than that approved facility.

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - $1,800 for Self Only enrollment, $3,600 for Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-Network - $2,600 for Self Only enrollment, $5,200 for Self Plus One enrollment and $5,200 for Self and Family enrollment each calendar year. The deductible applies to all benefits in this Section. Once an individual meets a $3,400 deductible under the Self Plus One or Self and Family enrollment, they will then be covered under Plan benefits. The remaining balance of the Self Plus One and Family deductible can be satisfied by one or more family members. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR NON-NETWORK FACILITY CARE**. Please refer to the precertification information shown in Section 3 to confirm which services require precertification.
- We define observation as monitoring patients following medical or surgical treatments to find out if they need more care, need admission or can be discharged. Observation care can be billed as Emergency Room, Outpatient, or Inpatient depending on where services are rendered, benefited accordingly and how it is billed to us within the scope of the facilities contract. Hospital observation cost share is determined as anything greater than 23 hours, and Aetna's policy is to allow up to 48 hours of hospital observation without preauthorization. After 48 hours, facilities must determine if they are going to discharge or admit the patient from observation and if admitting they will be responsible to preauthorize (if out-of-network member is responsible to preauthorize inpatient stay). Once admitted, inpatient member cost sharing will apply.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	**HDHP**
Room and board, such as • Private, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Whole blood and concentrated red blood cells not replaced by the member* • *Non-covered facilities, such as nursing homes, schools* • *Custodial care, rest cures, domiciliary or convalescent cares* • *Personal comfort items, such as a phone, television, barber service, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**HDHP**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • 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	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Outpatient hospital or ambulatory surgical center (cont.)	**HDHP**
• 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: Certain devices require precertification by you or your physician. Please See Section 3 for a list of services that require precertification. Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Note: In-network preventive care services are not subject to coinsurance listed.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Whole blood and concentrated red blood cells not replaced by the member.	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**HDHP**
Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 60-day limit per calendar year when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Custodial care	*All charges*
Hospice care	**HDHP**
Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of your attending Physician, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Ambulance	**HDHP**
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	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Ambulance - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Ambulance (cont.)	**HDHP**
4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency* • *Ambulette service* • *Ambulance transportation for member convenience or reasons that are not medically necessary* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - $1,800 for Self Only enrollment, $3,600 for Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-Network - $2,600 for Self Only enrollment, $5,200 for Self Plus One enrollment and $5,200 for Self and Family enrollment each calendar year. The deductible applies to all benefits in this Section. Once an individual meets a $3,400 deductible under the Self Plus One or Self and Family enrollment, they will then be covered under Plan benefits. The remaining balance of the Self Plus One and Family deductible can be satisfied by one or more family members. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We define observation as monitoring patients following medical or surgical treatments to find out if they need more care, need admission or can be discharged. Observation care can be billed as Emergency Room, Outpatient, or Inpatient depending on where services are rendered, benefited accordingly and how it is billed to us within the scope of the facilities contract. Hospital observation cost share is determined as anything greater than 23 hours, and Aetna's policy is to allow up to 48 hours of hospital observation without preauthorization. After 48 hours, facilities must determine if they are going to discharge or admit the patient from observation and if admitting they will be responsible to preauthorize (if out-of-network member is responsible to preauthorize inpatient stay). Once admitted, inpatient member cost sharing will apply.

What is a medical emergency?

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

What to do in case of emergency:

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

Benefit Description	You pay After the calendar year deductible…
Emergency	**HDHP**
• Emergency or urgent care at a doctor's office • Emergency or urgent care at an urgent care center • Emergency care as an outpatient (Emergency Room) in a hospital, including doctors' services	In-network: 15% of our Plan allowance Out-of-network: 15% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Elective or non-emergency care	*All charges*
Telehealth services	**HDHP**
• Teladoc Health consult	In-network: 15% of the consult fee Out-of-network: No benefit. Must use Teladoc Health provider.
• CVS Health Virtual Care™ consult	In-network: $55 per consult until the deductible is met, $0 per consult after deductible has been met Out-of-network: Not available
Please see www. aetnafeds.com/tools.php for information on medical and behavioral telehealth services. Members will receive a welcome kit explaining the telehealth benefits.	Please see www. aetnafeds.com/tools/php for information on medical and behavioral telehealth services.
Ambulance	**HDHP**
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member. Note: Air ambulance may be covered. Prior approval is required.	In-network: 15% of our Plan allowance Out-of-network: 15% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency* • *Ambulette service* • *Air ambulance without prior approval* • *Ambulance transportation for member convenience or for reasons that are not medically necessary*	*All charges*

Ambulance - continued on next page

Benefit Description	You pay After the calendar year deductible…
Ambulance (cont.)	**HDHP**
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 Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- The deductible is: In-network - $1,800 for Self Only enrollment, $3,600 for Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-Network - $2,600 for Self Only enrollment, $5,200 for Self Plus One enrollment and $5,200 for Self and Family enrollment each calendar year. The deductible applies to all benefits in this Section. Once an individual meets a $3,400 deductible under the Self Plus One or Self and Family enrollment, they will then be covered under Plan benefits. The remaining balance of the Self Plus One and Family deductible can be satisfied by one or more family members. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- **YOU MUST GET PREAUTHORIZATION FOR CERTAIN SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. Please see Section 3 of this brochure for a list of services that require preauthorization.
- 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 888-238-6240. A referral from your PCP is not necessary to access behavioral health care but your PCP may assist in coordinating your care.
- We will provide medical review criteria for denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional services	**HDHP**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Psychiatric office visits to Behavioral Health practitioner	In-network: 15% of our Plan allowance

Professional services - continued on next page

<table>
<tr><th>Benefit Description</th><th>You pay
After the calendar year deductible…</th></tr>
<tr><td>Professional services (cont.)</td><td>HDHP</td></tr>
<tr><td>• Substance Use Disorder (SUD) office visits to Behavioral Health practitioner
• Routine psychiatric office visits to Behavioral Health practitioner
• Behavioral therapy</td><td>In-network: 15% of our Plan allowance

Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.</td></tr>
<tr><td>Telehealth Behavioral Health consult</td><td>In-network: 15% of our Plan allowance

Out-of-network: Not covered</td></tr>
<tr><td>CVS Health Virtual Care™ telehealth consult</td><td>In-network: 15% of our Plan allowance

Out-of-network: Not available.</td></tr>
<tr><td>Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
• The services are ordered by a physician or independently licensed behavioral health professional (BHP) and are directly related to an active treatment plan of care established by the physician or licensed BHP; and
• Care is appropriate for the active treatment of a condition, illness or disease; and
• Care is intermittent or hourly in nature*; and
• Care is provided under the supervision of an independently licensed BHP; and
• Services take the place of a stay in a hospital or residential treatment facility (RTF), or receiving outpatient services outside of the home; and
• Treatment provided is appropriate for the member's condition including the amount of time spent providing the service as well as the frequency, type and duration of the services; and
• Services provided are not primarily for the comfort or convenience of the member or family or custodial in nature **.

* Intermittent or part-time skilled home behavioral health care is defined as a visit of up to 1 hour in duration.

** Custodial care is defined as services and supplies furnished to a person mainly to help him or her with activities of daily living. Custodial care includes services and supplies:

- Furnished mainly to train or assist the insured family member in personal hygiene and other activities of daily living rather than to provide therapeutic treatment; or

- That can be safely and adequately provided by persons without the technical skills of a health care provider (e.g., nurse).</td><td>In-network: 15% of our Plan allowance

Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.</td></tr>
<tr><td>Applied Behavior Analysis (ABA)

We cover medically necessary Applied Behavior Analysis (ABA) therapy when provided by network behavioral health providers. These providers include:</td><td>In-network: 15% of our Plan allowance

Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.</td></tr>
</table>

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional services (cont.)	**HDHP**
• Providers who are licensed or who possess a state-issued or state-sanctioned certification in ABA therapy. • Behavior analysts certified by the Behavior Analyst Certification Board (BACB). • Registered Behavior Technicians (RBTs) certified by the BACB or equivalent paraprofessionals who work under the supervision of a licensed provider or a certified behavior analyst. Note: Requires Precertification. See Section 3 “Other Services” under “You need prior Plan approval for certain services.” 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 888-238-6240.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.
Diagnostics	**HDHP**
• Psychological and Neuropsychological testing provided and billed by a licensed mental health and SUD treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.
Inpatient hospital or other covered facility	**HDHP**
Inpatient services provided and billed by a hospital or other covered facility including an overnight residential treatment facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.
Outpatient hospital or other covered facility	**HDHP**
Outpatient services provided and billed by a hospital or other covered facility including other outpatient mental health treatment such as: • Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician • Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician • Outpatient detoxification • Ambulatory detoxification which is outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications • Electro-convulsive therapy (ECT) • Transcranial magnetic stimulation (TMS) • Psychological/Neuropsychological testing	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between out allowance and the billed amount.

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

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- This is a five tier open formulary pharmacy plan, Advanced Control Formulary. The Formulary is a list of drugs that your health plan covers. With your Advanced Control Formulary Pharmacy plan, each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Each tier has a separate out-of-pocket cost.
  - Preferred generic
  - Preferred brand
  - Non-preferred generic and brand
  - Preferred specialty
  - Non-preferred specialty
- We cover prescribed drugs and medications, as described in the chart beginning on the third page. Copayment levels reflect in-network pharmacies only. If you obtain your prescription at an out-of-network pharmacy (non-preferred), you will be reimbursed at our Plan allowance less 40%. You are responsible for any difference between our Plan allowance and the billed amount.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- For prescription drugs and medications, you first must satisfy your deductible: In-network: $1,800 for Self Only enrollment, $3,600 for Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-Network $2,600 for Self Only enrollment, $5,200 for Self Plus One enrollment and $5,200 for Self and Family enrollment each calendar year. Once an individual meets a $3,400 deductible under the Self Plus One or Self and Family enrollment, they will then be covered under Plan benefits. The remaining balance of the Self Plus One and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section and is reduced by your HRA Fund, if applicable. While you are meeting this deductible, the cost of your prescriptions will automatically be deducted from your HRA Fund at the time of the purchase. If you are enrolled in the HSA, you will be responsible for the cost of the prescription. You may use your HSA debit card. The cost of your prescription is based on the contracted rate with network pharmacies. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
- Once you satisfy the deductible, you will then pay your member cost sharing at in-network retail pharmacies or the mail-order pharmacy for prescriptions under your Traditional medical coverage. You will pay 40% coinsurance plus the difference between our Plan allowance and the billed amount at out-of-network retail pharmacies. There is no out-of-network mail order pharmacy program.
- Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Upon approval by the Plan, the prescription is covered for the current calendar year or a specified time period, whichever is less.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

	• The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). We do not exclude coverage for entire classes of pharmaceuticals, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.	

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** Any retail pharmacy can be used for up to a 30-day supply. Our mail order program must be utilized for a 31-day up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay (retail pharmacy), and for a 31-day up to a 90-day supply of medication for two copays (mail order). For retail pharmacy transactions, you must present your Aetna Member ID card at the point of sale for coverage. Please call Member Services at 888-238-6240 for more details on how to use the mail order program. **Mail order is not available for drugs and medications ordered through a network Specialty Pharmacy. Prescriptions ordered through a network Specialty Pharmacy are only filled for up to a 30-day supply due to the nature of these prescriptions.** If accessing a nonparticipating pharmacy, the member must pay the full cost of the medication at the point of service, then submit a complete paper claim and a receipt for the cost of the prescription to our Direct Member Reimbursement (DMR) unit. Reimbursements are subject to review to determine if the claim meets applicable requirements, and are subject to the terms and conditions of the benefit plan and applicable law.
- **We use an open managed formulary.** The formulary is a list of drugs that your Plan covers. Drugs are prescribed by attending licensed doctors and covered in accordance with the Pharmacy Drug (Formulary) Guide. Certain drugs require your doctor to get precertification or step therapy from the Plan before they can be covered under the Plan. Your prescription drug plan includes drugs listed in the Pharmacy Drug (Formulary) Guide. Prescription drugs listed on the formulary exclusions list are excluded unless a medical exception is approved by the Plan. If it is medically necessary for you to use a prescription drug on the Formulary Exclusions List, you or your prescriber must request a medical exception. Please see our online formulary and drug pricing search tools at the following www. aetnafeds.com/pharmacy.php or call us at 888-238-6240.
- **Drugs not on the formulary.** Formularies are developed and reviewed by the CVS Caremark 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 and safety 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 the Plan to re-evaluate the generic for possible inclusion on the formulary. We will place some of these generic drugs that are granted a period of exclusivity on our non-formulary list, which requires the highest copay level. **Remember, a generic equivalent will be dispensed, if available, unless your physician specifically requires a brand name and writes "Dispense as written" (DAW) on the prescription, so discuss this with your doctor.**
- **Choose generics.** The Plan requires the use of generics if a generic drug is available. If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance* unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained from the Plan. Generics contain the same active ingredients in the same amounts as their brand name counterparts and have been approve by the FDA. By using generic drugs, you will see cost savings, without jeopardizing clinical outcome or compromising quality. * The differential/penalty will not apply to Plan accumulators (example: deductible and out-of-pocket maximum)

- **Precertification.** Your pharmacy benefits plan includes precertification. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-approved 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 precertification for a drug. Step-therapy is another type of precertification. Certain medications will be excluded from coverage unless you try one or more "step" drug(s) first, or unless a medical exception is obtained. The drugs requiring precertification or step-therapy are subject to change. Visit our website at www. aetnafeds.com for the most current information regarding the precertification and step-therapy lists. Ask your physician if the drugs being prescribed for you require precertification or step therapy.
- **When to use a participating retail or mail order pharmacy.** Covered prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy may be dispensed for up to a 30-day supply. Members must obtain a 31-day up to a 90-day supply of covered prescription medication through mail order. In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available, unless your physician specifically requires a brand name. While mail order is most likely the most cost effective option for most prescriptions, there may be some instances where the most cost effective option for members will be to utilize a retail pharmacy for a 30 day supply versus mail order. Members should utilize the Cost of Care Tool prior to ordering prescriptions through mail order to determine the cost.

  In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filing of their medication(s) prior to departure, their pharmacist will need to contact Aetna. Coverage of additional prescriptions will only be allowed if there are refills remaining on the member's current prescription or a new prescription has been issued by their physician. The member is responsible for the applicable copayment for the additional prescription.
- The Plan allows coverage of a medication refill when at least 80% of the previous prescription according to the physician's prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a prescription refill to be covered 24 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, 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.
- **Mail order pharmacy**. Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Outpatient prescription drugs are covered when dispensed by a network mail order pharmacy or a CVS pharmacy®. Each prescription is limited to a maximum 90-day supply. Prescriptions for less than a 30-day supply or more than a 90-day supply are not eligible for coverage when dispensed by a network mail order pharmacy.
- **Specialty drugs**. Specialty drugs are medications that treat complex, chronic diseases which includes select oral, injectable and infused medications. The first fill including all subsequent refills of these medications must be obtained through a network specialty pharmacy.

  Certain Specialty Formulary medications identified on the Specialty Drug List 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 cost-sharing. If you obtain the prescribed medications directly from a network 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. For a detailed listing of specialty medications visit www. aetnafeds.com/pharmacy.php or contact us at 800-537-9384 for a copy. Note that the medications and categories covered are subject to change. **Some specialty medications may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, you shall not receive credit toward your out-of-pocket maximum or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.**

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

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	**HDHP**
We cover the following medications and supplies prescribed by your licensed attending physician or dentist and obtained from a Plan pharmacy or through our mail order program or an out-of-network retail pharmacy: • Drugs and medicines approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as *Not covered* • Self-injectable drugs • Diabetic supplies limited to: - Lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips - Insulin - Disposable needles and syringes for the administration of covered medications • Prenatal vitamins (as covered under the Plan's formulary) • Medications prescribed to treat obesity • Oral and Injectable Infertility medications (includes Artificial Insemination (AI), In vitro fertilization (IVF)/ART medications) (Limited to $25,000 per member per calendar year) 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. Note: Certain drugs to treat infertility are considered specialty drugs. Please see Specialty drugs in this section. Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat nicotine dependence are covered under the Tobacco cessation program. (See Section 5(a)). OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	**In-network:** The full cost of the prescription is applied to the deductible before any benefits are considered for payment under the pharmacy plan. Once the deductible is satisfied, the following will apply: Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per Preferred Generic (PG) formulary drug; 50% up to $200 maximum per Preferred Brand (PB) name formulary drug; 50% up to $300 maximum per covered Non-Preferred (NP) (generic or brand name) drug. Mail Order Pharmacy or CVS Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 per Preferred Generic (PG) formulary drug 50% up to $400 maximum per Preferred Brand (PB) name formulary drug; 50% up to $600 maximum per covered Non-Preferred (NP) (generic or brand name) drug. **Out-of-network (retail pharmacies only):** 40% plus the difference between our Plan allowance and the billed amount.

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**HDHP**
Contraceptive drugs and devices as listed in the Health Resources and Services Administration ACA/HRSA site www. hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Visit www. aetnafeds.com/familyplanning.php for more information on contraception and the the exception process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: If it is medically necessary for you to use a prescription drug on the Formulary Exclusions List, you or your prescriber must request a medical exception. Visit our website at www. aetnafeds.com/pharmacy.php to review our Pharmacy Drug (Formulary) Guide or call us at 888-238-6240.	See coverage below
Women's contraceptive drugs and devices • Generic oral contraceptives on our formulary list • Generic emergency contraception, including over-the-counter (OTC) when filled with a prescription • Generic injectable contraceptives on our formulary list - five (5) vials per calendar year • Diaphragms - one (1) per calendar year • Brand name Intra Uterine Device • Generic patch contraception	**In-network:** Nothing **Out-of-network (retail pharmacies only):** 40% plus the difference between our Plan allowance and the billed amount.
• Brand name contraceptive drugs • Brand name injectable contraceptive drugs such as Depo Provera - five (5) vials per calendar year • Brand emergency contraception	Retail Pharmacy, for up to a 30-day supply per prescription or refill: 50% up to $200 maximum per Preferred Brand (PB) name formulary drug; 50% up to $300 maximum per covered Non-Preferred (NP) (generic or brand name) drug. Mail Order Pharmacy or CVS Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: 50% up to $400 maximum per Preferred Brand (PB) name formulary drug;

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**HDHP**
	50% up to $600 maximum per covered Non-Preferred (NP) (generic or brand name) drug. **Out-of-network (retail pharmacies only):** 40% plus the difference between our Plan allowance and the billed amount.
Specialty Medications **Specialty medications must be filled through a network specialty pharmacy.** These medications are not available through the mail order benefit. Certain Specialty Formulary medications identified on the Specialty Drug List may be covered under the medical or pharmacy section of this brochure. Please refer to above, Specialty Drugs for more information or visit: www. aetnafeds.com/pharmacy.php.	Up to a 30-day supply per prescription or refill: Preferred Specialty (PSP): 50% up to a $350 maximum Non-preferred Specialty (NPSP): 50% up to $700 maximum
Limited benefits: • Drugs to treat erectile dysfunction are limited up to six (6) tablets per 30-day period.	**In-network:** Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per Preferred Generic (PG) formulary drug; 50% up to $200 maximum per Preferred Brand (PB) name formulary drug; 50% up to $300 maximum per covered Non-Preferred (NP) (generic or brand name) drug. **Out-of-network** (retail pharmacies only)**:** 40% plus the difference between our Plan allowance and the billed amount.
Preventive care medications	**HDHP**
Medications to promote better health as recommended by ACA. Drugs and supplements are covered without cost-share which includes over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. We will cover preventive medications in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations/guidance: • Aspirin • Folic acid supplements • Oral Fluoride • Statins • Breast Cancer Prevention drugs • HIV PrEP • Nicotine Replacement Medications (Limits apply)	**In-network:** Nothing

Preventive care medications - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care medications (cont.)	**HDHP**
• Bowel Prep Medications (Required with preventive Colonoscopy) Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from an in-network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at: www. fda.gov/ consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go towww. findtreatment.samhsa.gov/ Please refer to the formulary guide for a complete list of preventive drugs including coverage details and limitations: www. aetnafeds.com/ pharmacy.php Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. For current recommendations go to www. uspreventiveservicestaskforce.org/ BrowseRec/Index/browse-recommendations.	**In-network:** Nothing
Not covered: • *Drugs for cosmetic purposes, such as Rogaine* • *Drugs to enhance athletic performance* • *Nonprescription medications unless specifically indicated elsewhere* • *Medical supplies such as dressings and antiseptics* • *Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug) unless required by law or covered by the plan.* • *Lost, stolen or damaged drugs* • *Vitamins (including prescription vitamins), nutritional supplements, and any food item, including infant formula, medical foods and other nutritional items not listed as a covered benefit, even if it is the sole source of nutrition unless otherwise stated.* • *Prophylactic drugs including, but not limited to, anti-malarials for travel* • *Compounded bioidentical hormone replacement (BHR) therapy that includes progesterone, testosterone and/or estrogen.* • *Compounded thyroid hormone therapy* • *Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria*	*All charges*

Preventive care medications - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care medications (cont.)	**HDHP**
If you are mid-treatment under this plan, within a chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. You may be eligible for our continuation of care process only if the covered chemical regimen was initiated, with prior approval, before January 1, 2026. Please refer to www. aetnafeds.com/gender-affirming-care.php for additional details, forms and requirements regarding the continuation of care process. If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process. *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

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

Benefit Description	You Pay After the calendar year deductible...
Accidental injury benefit	**HDHP**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Dental benefits	**HDHP**
See Section 5 for Dental Preventive Care	See Section 5 for Dental Preventive Care

Section 5. Aetna Direct Health Plan Benefits

See Summary of Benefits for a benefits summary.

Section 5. Aetna Direct Health Plan Benefits Overview

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

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

With this Plan, in-network preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described in Section 5. Traditional Medical Coverage Subject to the Deductible.

Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible. Your out-of-pocket costs for services that both Medicare Part A or B and we cover depends on whether your physician accepts Medicare assignment for the claim:

- If your physician accepts Medicare assignment, then you pay nothing for covered charges.
- If your physician does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment.

• **In-network Medical, Preventive Care**	The Plan covers preventive care services, such as periodic health evaluations (e.g., routine physicals), screening services (e.g., routine mammograms), well-child care, routine child and adult immunizations. These services are covered at 100% if you use a network provider. The services are described in Section 5, In-Network Medical, Preventive Care.
• **Traditional medical coverage subject to the deductible**	After you have paid the Plan's deductible (In-network: $1,600 for Self Only enrollment, $3,200 for Self Plus One enrollment and $3,200 for Self and Family enrollment and Out-of-network: $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment), we pay benefits under Traditional medical coverage described in Section 5. The Plan typically pays 80% for in-network care and 60% for out-of-network care. Once an individual meets the Self Only deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One or Self and Family deductible can be satisfied by one or more family members. The deductibles for in-network and out-of-network do not cross apply and will need to be met separately for traditional benefits to begin. ***If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible and your coinsurance for most medical services.** (See Section 5 for details) **Note:** The **annual deductible** will be waived for prescription drug benefits, but cost sharing as outlined in Section 5(f) will still apply if Medicare Part A and B are primary. **Covered services include:** • Medical services and supplies provided by physicians and other health care professionals • Surgical and anesthesia services provided by physicians and other health care professionals • Hospital services; other facility or ambulance services • Emergency services/accidents • Mental health and substance use benefits • Prescription drug benefits • Special features

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

Your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $6,000 for Self Only, $12,000 for Self Plus One, or $12,000 for Self and Family enrollment in-network and $7,000 for Self Only enrollment, $14,000 for Self Plus One enrollment or $14,000 for Self and Family enrollment out-of-network. Once an individual meets the Self Only out-of-pocket maximum under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical expenses at 100%. The remaining balance of the Self Plus One or Self and Family out-of-pocket maximum can be satisfied by one or more family members. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and Aetna Direct Section 5 Traditional medical coverage subject to the deductible for more details. In-network and out-of-network out-of-pocket maximums do not cross apply and will need to be met separately in order for eligible medical expenses to be paid at 100%.

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

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

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

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

Aetna Member website gives you direct access to:

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

Section 5. Medical Preventive Care

Important things you should keep in mind about these benefits:

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

***Note: If you are covered by Medicare Part A and B and it is primary, your out-of-pocket costs for services that both Medicare Part A or B and we cover depend on whether your provider accepts Medicare assignment for the claim.**

- **If your provider accepts Medicare assignment, then you pay nothing for covered charges.**
- **If your provider does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the provider's charge (whichever is less) and our payment combined with Medicare's payment.**

Note: We do not waive benefit limitations. In addition, we do not waive any coinsurance or copayments for prescription drugs.

Benefit Description	You pay
Medical Preventive Care, adult	**Aetna Direct**
• Routine physicals - one (1) exam every calendar year The following preventive services are covered at the time interval recommended at each of the links below. • U.S. Preventive Services Task Force (USPSTF) A and B recommends screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https ://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (See Section 5).

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay
Medical Preventive Care, adult (cont.)	**Aetna Direct**
• Adult Immunizations endorsed by the Centers for Disease Control (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. for a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at www. cdc.gov/vaccines/imz-schedules/index.html • Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at www. hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (See Section 5).
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, limited to 26 visits per person per calendar year • Counseling programs when medically identified to support obesity prevention and management by an in-network provider Note: When anti-obesity medication is prescribed, Section 5(f). Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity, see Section 5(b).	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (See Section 5).
Routine mammogram - covered • One (1) every calendar year; or when medically necessary • The following exams limited to: - One (1) routine eye exam every 12 months - One (1) routine hearing exam every 24 months Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 888-238-6240 for information on whether a specific test is considered routine. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (See Section 5).

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay
Medical Preventive Care, adult (cont.)	**Aetna Direct**
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, license, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Medical Preventive Care, children	**Aetna Direct**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Children's immunizations endorsed by the Center for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at www. cdc.gov/vaccines/imz-schedules/index.html • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • To build your personalized list of preventive services go to https://health.gov/myhealthfinder • Well-child care charges for routine examinations, immunizations and care (up to age 22) - Seven (7) routine exams from birth to age 12 months - Three (3) routine exams from age 12 months to 24 months - Three (3) routine exams from age 24 months to 36 months - One (1) routine exam per year thereafter to age 22 • Hearing loss screening of newborns provided by a participating hospital before discharge • One (1) routine hearing exam every 24 months through age 17 to determine the need for hearing correction • One (1) routine eye exam every 12 months through age 17 to determine the need for vision correction	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (See Section 5).
• Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to comprehensive, intensive nutrition and behavioral weight-loss therapy and counseling programs under the USPSTF A and B recommendations. These programs are covered as part of prevention and treatment of obesity as follows: - Comprehensive, intensive nutrition and behavioral weight-loss counseling therapy Note: When anti-obesity medication is prescribed, see Section 5 (f).	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (See Section 5).

Medical Preventive Care, children - continued on next page

Benefit Description	You pay
Medical Preventive Care, children (cont.)	**Aetna Direct**
Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity, see Section 5(b). Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 888-238-6240 for information on whether a specific test is considered routine. Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your Medical Fund are subject to your deductible until satisfied and then subject to Traditional medical coverage (See Section 5).
Not covered: • *Physical exams, required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters and medications for travel or work-related exposure.*	*All charges*

Section 5. Medical Fund

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- All eligible medical care expenses up to the Plan allowance in Section 5 (except in-network medical preventive care) are paid from your Medical Fund. Traditional medical coverage will start once your deductible is satisfied.
- Note that in-network medical preventive care covered under Section 5 does NOT count against your Medical Fund.
- The Medical Fund provides full coverage for eligible expenses from both in-network and non- network providers. However, your Medical Fund will generally go much further when you use network providers because network providers agree to discount their fees. Note: The Medical Fund does not reduce the deductible and/or the out-of-pocket maximum.
- You can track your Medical Fund on the Aetna Member website, by phone at 888-238-6240 (toll-free), or, when you incur claims, with monthly statements mailed directly to you at home.
- Whenever you join this Plan, your annual deductible will apply as of your effective date. **(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible).**
- If a subscriber begins the year under Self Only enrollment and then switches to Self Plus One enrollment or Self and Family enrollment, the Medical Fund will increase from $900 to $1,800. We will deduct any amounts used while under the Self Only enrollment from the Self Plus One enrollment or Self and Family enrollment of $1,800. If the subscriber begins the year under Self Plus One or Self and Family enrollment and later switches to Self Only enrollment, the Medical Fund will decrease from $1,800 to $900. We will deduct amounts of the Medical Fund previously used while enrolled in the Self Plus One or Self and Family from the Self Only enrollment amount of $900. For example, if $650 of the Self and Family Medical Fund had been used and the subscriber changes to Self Only coverage, the Medical Fund will be $900 minus $650 or $250 for the balance of the year. Members will not be penalized for amounts used while in Self Plus One or Self and Family enrollment that exceed the amount of the Self Only Medical Fund.
- Medicare premium reimbursement – Medicare participating annuitants may request reimbursement for Medicare Part B premiums paid if Medical Fund dollars are available. Please contact us at 888-238-6240 for more information. The Plan does not reimburse for Medicare Part D. **Note: The Medical fund always pays if there are funds available. For example: if you have Medicare Part A & B primary and your deductible is waived. The Medical fund will be used to pay your copay or coinsurance for pharmacy claims.**
- If you terminate your participation in this Plan, any remaining Medical Fund balance will be forfeited.

YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN- NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON- NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR NON-NETWORK FACILITY CARE. Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

*** Note: If you are covered by Medicare Part A and B and it is primary, your out-of-pocket costs for services that both Medicare Part A or B and we cover depend on whether your provider accepts Medicare assignment for the claim.**

- **If your provider accepts Medicare assignment, then you pay nothing for covered charges.**
- **If your provider does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the provider's charge (whichever is less) and our payment combined with Medicare's payment.**

Note: We do not waive benefit limitations. In addition, we do not waive any coinsurance or copayments for prescription drugs.	

Benefit Description	You pay
Medical Fund	**Aetna Direct***
A Medical Fund is provided by the Plan for each enrollment. Each year the Plan adds to your account. For 2026, the Medical Fund is: • $900 per year for a Self Only enrollment, or; • $1,800 per year for a Self Plus One enrollment, or; • $1,800 per year for a Self and Family enrollment. The Medical Fund covers eligible expenses at 100%. For example, if you are ill and go to a network doctor for a $75 visit, the doctor will submit your claim and the cost of the visit will be deducted automatically from your Medical Fund; you pay nothing. Balance in Medical Fund for Self Only $900 Less: Cost of visit - $75 Remaining Balance in Medical Fund $825 Medical Fund expenses are the same medical, surgical, hospital, emergency, mental health and substance abuse, and prescription drug services and supplies covered under the Traditional medical coverage (See Section 5 for details). To make the most of your Medical Fund, you should: • Use the network providers whenever possible; and • Use generic prescriptions whenever possible **Medical Fund Rollover** Provided you remain enrolled in this Option, any unused, remaining balance in your Medical Fund at the end of the calendar year may be rolled over to subsequent years. Note: This rollover feature can increase your Medical Fund in the following year(s) up to a maximum rollover of $5,000 Self Only enrollment, $10,000 Self Plus One enrollment or $10,000 Self and Family enrollment.	In-network and out-of-network: Nothing up to your available Medical Fund balance. However, you are responsible for non-network medical fees that exceed our Plan allowance.
Not covered: • *Non-network preventive care services not included under Section 5* • *Services or supplies shown as not covered under Traditional medical coverage (See Section 5)* • *Charges of non-network providers that exceed our Plan allowance.*	*All charges*

Section 5. Traditional Medical Coverage Subject to the Deductible

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your deductible is $1,600 for Self Only enrollment, $3,200 for Self Plus One enrollment and $3,200 for Self and Family enrollment in-network and $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment out-of-network. The deductible applies to all benefits in this Section. Once an individual meets the Self Only deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductibles for in-network and out-of-network do not cross apply and will need to be met separately for traditional benefits to begin. **(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible)**
- Your Medical Fund ($900 Self Only enrollment, $1,800 Self Plus One enrollment and $1,800 for Self and Family enrollment) and any rollover funds from prior years must be used first for eligible health care expenses. Note: The Medical Fund does not reduce the deductible and/or the out-of-pocket maximum.
- Traditional medical coverage does not begin until you have used your Medical Fund and satisfied your deductible.
- Prescription drug benefits change to a copayment/coinsurance levels once you satisfy your deductible. See Section 5(f).
- In-network medical preventive care is covered at 100% under Section 5 and does not count against your Medical Fund.
- The Medical Fund provides coverage for both in-network and non-network providers. Under the Traditional medical coverage, in-network benefits apply only when you use a network provider. Out-of-network benefits apply when you do not use a network provider.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR NON-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

*** Note: If you are covered by Medicare Part A and B and it is primary, your out-of-pocket costs for services that both Medicare Part A or B and we cover depend on whether your provider accepts Medicare assignment for the claim.**

- **If your provider accepts Medicare assignment, then you pay nothing for covered charges.**
- **If your provider does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the provider's charge (whichever is less) and our payment combined with Medicare's payment.**

Note: We do not waive benefit limitations. In addition, we do not waive any coinsurance or copayments for prescription drugs.

Benefit Description	You pay
Your deductible before Traditional medical coverage begins	**Aetna Direct***
Once your Medical Fund has been exhausted, you must satisfy your deductible before your Traditional medical coverage begins. The Self Plus One or Self and Family deductible can be satisfied by one or more family members. Once your deductible is satisfied, you will be responsible for your coinsurance amounts for eligible medical expenses until you meet the annual catastrophic out-of-pocket maximum. You also are responsible for copayments for eligible prescriptions.*	100% of allowable charges until you meet the deductible of $1,600 per Self Only enrollment, $3,200 per Self Plus One enrollment or $3,200 per Self and Family enrollment in-network and $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment out-of-network. The deductibles for in-network and out-of-network do not cross apply and will need to be met separately for traditional benefits to begin. **(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible)**

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your deductible is $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment in-network and $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment out-of-network. Once an individual meets the Self Only deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section. The deductibles for in-network and out-of-network do not cross apply and will need to be met separately for traditional benefits to begin. **(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible).**
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, Your Costs for Covered Services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i. e., hospital, surgical center, etc.).

*** Note: If you are covered by Medicare Part A and B and it is primary, your out-of-pocket costs for services that both Medicare Part A or B and we cover depend on whether your provider accepts Medicare assignment for the claim.**

- **If your provider accepts Medicare assignment, then you pay nothing for covered charges.**
- **If your provider does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the provider's charge (whichever is less) and our payment combined with Medicare's payment.**

Note: We do not waive benefit limitations. In addition, we do not waive any coinsurance or copayments for prescription drugs.

Benefit Description	You pay After the calendar year deductible...	
(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible)		
Diagnostic and treatment services	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Professional services of physicians • In physician's office - Office medical evaluations, examinations and consultations - Second surgical or medical opinion - Initial examination of a newborn child	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Diagnostic and treatment services (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• In an urgent care center • During a hospital stay • In a skilled nursing facility • At home • Walk-In Clinic	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Telehealth services	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Teladoc Health consult	In-network: 20% of the consult fee Out-of-network: No benefit. Must use Teladoc Health provider.	In-network: 0% per consult Out-of-network: No benefit. Must use Teladoc Health provider.
• CVS Health Virtual Care™	In-network: $55 per consult until the deductible is met, $0 per consult after deductible has been met Out-of-network: Not available	In-network: $0 per consult Out-of-network: Not available
Please see www. aetnafeds.com/tools.php for information on medical and behavioral telehealth services. Members will receive a welcome kit explaining the telehealth benefits. Refer to Section 5(e) for behavioral health telehealth consults.	Not applicable.	Not applicable.
Lab, X-ray and other diagnostic tests	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CT Scans/MRI* • Ultrasound • Electrocardiogram and electroencephalogram (EEG) * Note: CT Scans and MRIs require precertification, see “Other Services” under “You need prior Plan approval for certain services" in Section 3.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

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

Benefit Description	You pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Genetic Counseling and Evaluation for BRCA Testing • Genetic Testing for BRCA-Related Cancer* *Note: Requires precertification. See “Other Services” under “You need prior Plan approval for certain services" in Section 3.	In-network: Nothing at a network provider Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: Nothing at a network provider Out-of-network: All charges until you satisfy your deductible, then 40% of our Plan allowance and any difference between our allowance and the billed amount.
Maternity care	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Complete maternity (obstetrical) care, such as: • Routine 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 and counseling for prenatal and postpartum depression Note: Items not considered routine include (but not limited to) - Amniocentesis - Certain Pregnancy diagnostic lab tests - Delivery including Anesthesia - Fetal Stress Tests - High Risk Specialist Visits - Inpatient admissions - Ultrasounds • Screening for gestational diabetes • Delivery • Postnatal care Notes: • You do not need to precertify your vaginal delivery; see below for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. To enroll in the Enhanced Maternity program, call toll-free 1-800-272-3531.	In-network: No coinsurance for routine prenatal care or the first postpartum care visit when services are rendered by an in-network delivering health care provider. For postpartum care visits thereafter: In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: No coinsurance for routine prenatal care or the first postpartum care visit when services are rendered by an in-network delivering health care provider. For postpartum care visits thereafter: In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Maternity care (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• You may remain in the hospital up to three (3) days after a vaginal delivery and five (5) days after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non- routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. • See Hospital benefits in Section 5(c) and Surgical Services in Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	In-network: No coinsurance for routine prenatal care or the first postpartum care visit when services are rendered by an in-network delivering health care provider. For postpartum care visits thereafter: In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: No coinsurance for routine prenatal care or the first postpartum care visit when services are rendered by an in-network delivering health care provider. For postpartum care visits thereafter: In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Breastfeeding and lactation support, supplies and counseling for each birth	In-network: Nothing at a network provider. Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Home births	*All charges*	*All charges*
Family planning	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories in the HRSA supported guidelines. This list includes: • Voluntary female sterilization • Contraceptive counseling on an annual basis • Surgically implanted contraceptives • Generic injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f).	In-network: Nothing Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: Nothing Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Family planning - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Family planning (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below. Visit www. AetnaFeds.com/FamilyPlanning.php for more information on contraception and the exception process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Note: We cover injectable contraceptives under the medical benefit when supplied by and administered at the provider's office. Injectable contraceptives are covered at the prescription drug benefit when they are dispensed at the Pharmacy. If a member must obtain the drug at the pharmacy and bring it to the provider's office to be administered, the member would be responsible for both the Rx and office visit cost shares. We cover oral contraceptives under the prescription drug benefit.	In-network: Nothing Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: Nothing Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
• Voluntary sterilization (See Section 5(b) Surgical Procedures)	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Infertility services	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Infertility is a disease defined as when a person is unable to conceive or produce conception after one year of egg-sperm contact when the individual attempting conception is under 35 years of age, or after six months of egg-sperm contact when the individual attempting conception is 35 years of age or older. Egg-sperm contact can be achieved by regular sexual intercourse or artificial insemination (intrauterine, intracervical, or intravaginal) as stated in our medical clinical policy bulletin (See Section 10. for definition of Medical Necessity for additional details on Aetna's Clinical Policy). This definition applies to all individuals regardless of sexual orientation or the presence/availability of a reproductive partner. Infertility may also be established by the demonstration of a disease or condition of the reproductive tract such that egg-sperm contact would be ineffective. • Testing for diagnosis and surgical treatment of the underlying medical cause of infertility. **Artificial insemination (AI)* **** • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI)	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details). Note: If you receive these services during an inpatient admission then facility charges will apply. See Section 5(c) for applicable facility charges.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details). Note: If you receive these services during an inpatient admission then facility charges will apply. See Section 5(c) for applicable facility charges.
Advanced Reproductive Technologies (ART):* ** (Combined limit of 3 cycles of Ovulation Induction and In vitro fertilization (IVF) per calendar year) • Ovulation Induction • Egg retrieval and fertilization • Intracytoplasmic sperm injection (ICSI) • Embryo transfer We limit Ovulation Induction and In Vitro Fertilization (IVF) to 3 cycles per calendar year. The Plan defines a "cycle" as: • Ovulation induction cycle(s) while on injectable medication (including but not limited to menotropins, hCG, GnRH) to stimulate the ovaries. *(See Section 5(f) for coverage) • Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician * • Injectable fertility drugs including but not limited to menotropins, hCG, and GnRH agonists. (See Section 5(f) for coverage)* You are eligible for covered ovulation induction medication cycles if: • You or your partner have been diagnosed with infertility.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details). Note: If you receive these services during an inpatient admission then facility charges will apply. See section 5(c) for applicable facility charges.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details). Note: If you receive these services during an inpatient admission then facility charges will apply. See section 5(c) for applicable facility charges.

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• You have met the requirement for the number of months trying to conceive through egg and sperm contact. • Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's infertility clinical policy You are eligible for IVF if you meet our medical necessity criteria, which includes: • Natural or artificial insemination would not be expected to be effective, and ART would be expected to be the only effective treatment OR • You have met the requirement for the number of months trying to conceive through egg and sperm contact (For women under 35 years of age, an appropriate trial of egg-sperm contact requires 12 months of regular intravaginal inseminations or 4 cycles of timed intrauterine or intracervical inseminations, documented in the medical record. For women 35 years of age and older, an appropriate trial of egg-sperm contact requires 6 months of regular intravaginal inseminations or 3 cycles of timed intrauterine or intracervical insemination, documented in the medical record); • You have met the requirement for trying to conceive through ovulation induction (3 cycles for women 37 years of age or younger); AND • You or your partner have not gone through voluntary sterilization with or without reversal; AND • Your unmedicated day three (3) Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's Clinical Policy Bulletin (CPB) for Infertility. Note: The Plan does not cover infertility drugs under the medical benefit. See Section 5(f) for coverage.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details). Note: If you receive these services during an inpatient admission then facility charges will apply. See section 5(c) for applicable facility charges.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details). Note: If you receive these services during an inpatient admission then facility charges will apply. See section 5(c) for applicable facility charges.
Iatrogenic Infertility* ** • Fertility preservation procedures (retrieval of and freezing of eggs or sperm) for members facing iatrogenic infertility caused by chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or ovary or testicle removal for treatment of disease. • Storage of Embryo(s), Egg(s), Sperm for one year for members facing iatrogenic infertility. * ** Note: Storage costs are only covered for members who have undergone an approved fertility preservation procedure while covered under the Plan.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details).	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details).

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
	Note: If you receive these services during an inpatient admission then facility charges will apply. See section 5(c) for applicable facility charges.	Note: If you receive these services during an inpatient admission then facility charges will apply. See section 5(c) for applicable facility charges.
Aetna's National Infertility Unit Our NIU is here to help you and is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with understanding your benefits and the medical precertification process. You can learn more at www.AetnaInfertilityCare.com or call the NIU at 1-800-575-5999 (TTY: 711). * Subject to medical necessity ** Note: Requires Precertification. See Section 3 "Other Services" under "You need prior Plan approval for certain services." 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 888-238-6240. Your network provider will request approval from us in advance for your infertility services. If your provider is not a network provider, you are responsible to request approval from us in advance.	Not applicable.	Not applicable.
Not covered: • *All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle (except for those medically necessary services as stated above). These include, but are not limited to:* - *Imaging, laboratory services, and professional services* - *In vitro fertilization (IVF)* - *Zygote intrafallopian transfer (ZIFT)* - *Gamete intrafallopian transfer (GIFT)* - *Cryopreserved embryo transfers* - *Gestational carrier cycles* - *Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).* • *Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue (unless noted as covered)*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• *All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father* • *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 ART procedures except as stated above* • *Services and supplies related to the above mentioned services, including sperm processing* • *Services associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g. office, hospital, ultrasounds, laboratory tests etc. (unless noted in covered section of iatrogenic infertility)* • *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. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization* • *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* • *Elective fertility preservation, such as egg freezing sought due to natural aging* • *Infertility treatments such as in vitro fertilization that might be needed after the necessary medical intervention (unless medical necessity is met for infertility benefits)* • *Storage costs (except for one year of storage as noted in covered section of iatrogenic infertility)* • *Obtaining sperm from a person not covered under this plan* • *Infertility treatment when a successful pregnancy could have been obtained through less costly treatment*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• *Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause)as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy* • *Oral and Injectable infertility (See Section 5f)* • *Any infertility service rendered that requires precertification without a prior authorization* • *Coverage for services received by a spouse or partner who is not a covered member under the plan*	*All charges*	*All charges*
Allergy care	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Testing and treatment • Allergy injection • Allergy serum*	In-network: 20% of our Plan allowance Nothing for serum* Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Nothing for serum* Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• 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 in Section 5(b). • Respiratory and inhalation therapy • Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy in a doctor's office or facility (For IV infusion and antibiotic treatment at home, see Home Health Services.) • Growth hormone therapy (GHT) Note: We cover growth hormone injectables under the prescription drug benefit.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission or outpatient visit, then facility charges will apply. See Section 5(c) for applicable facility charges.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission or outpatient visit, then facility charges will apply. See Section 5(c) for applicable facility charges.

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Treatment therapies (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Note: We will only cover GHT when we preauthorize the treatment. Call 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. Note: Applied Behavior Analysis (ABA) – Children with autism spectrum disorder is covered under mental health. (See Section 5(e))	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission or outpatient visit, then facility charges will apply. See Section 5(c) for applicable facility charges.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission or outpatient visit, then facility charges will apply. See Section 5(c) for applicable facility charges.
Physical and occupational therapies	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• 60 visits per person, per calendar year for physical or occupational therapy, or a combination of both for the services of each of the following: - Qualified Physical therapists - Occupational therapists Note: We only cover therapy when a physician: • Orders the care • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed. Note: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient therapy is covered under Hospital/Extended Care Benefits. • Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome Note: Physical therapy treatment of lymphedemas following breast reconstruction surgery is covered under the Reconstructive surgery benefit - see Section 5(b).	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission or outpatient visit, then facility charges will apply. See Section 5(c) for applicable facility charges.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount. Note: If you receive these services during an inpatient admission or outpatient visit, then facility charges will apply. See Section 5(c) for applicable facility charges.
Not covered: • *Long-term rehabilitative therapy*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Pulmonary and cardiac rehabilitation	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• 20 visits per condition per member per calendar year for pulmonary rehabilitation to treat functional pulmonary disability. • Cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or a myocardial infarction is provided for up to 3 visits a week for a total of 18 visits.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Long-term rehabilitative therapy	*All charges*	*All charges*
Habilitative Services	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Habilitative services for congenital or genetic birth defects including, but not limited to, autism or an autism spectrum disorder, and developmental delays. Treatment is provided to enhance the ability to function. Services include occupational therapy, physical therapy and speech therapy.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Speech therapy	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• 60 visits per person, per calendar year.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Hearing services (testing, treatment, and supplies)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Routine hearing exam covered once every 24 months Note: Discounts on hearing exams, hearing services, and hearing aids are also available. Please see the Non-FEHB Benefits Section of this brochure for more information.	In-network: Nothing Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: Nothing Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Hearing aids limited to $3,000 every three (3) calendar years	All charges above $3,000. Note: member will be reimbursed up to the allowed amount.	All charges above $3,000. Note: member will be reimbursed up to the allowed amount.
Not covered: • *All other hearing testing and services that are not shown as covered*	*All charges*	*All charges*

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Hearing services (testing, treatment, and supplies) (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• *Hearing aids charges over $3,000 every three (3) years, testing and examinations for them*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Treatment of eye diseases and injury	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not Covered: • *Corrective eyeglasses and frames or contact lenses* • *Fitting of contact lenses* • *Vision therapy, including eye patches and eye exercises, e. g., orthoptics, pleoptics, for the treatment of conditions related to learning disabilities or developmental delays* • *Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors*	*All charges*	*All charges*
Foot care	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (except for surgical treatment)* • *Foot orthotics* • *Podiatric shoe inserts*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Orthopedic devices such as braces and corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and prosthetic devices such as artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), penile implants, defibrillator surgically implanted breast implant following mastectomy, and lenses following cataract removal. See Surgical Section 5(b) for coverage of the surgery to insert the device. • Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.) Note: Certain devices require precertification by you or your physician. Please see Section 3 for a list of services that require precertification.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
• Hair prosthesis prescribed by a physician for hair loss resulting from radiation therapy, chemotherapy or certain other injuries, diseases, or treatment of a disease. Note: Plan lifetime maximum of $500.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Orthopedic and corrective shoes not attached to a covered brace* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *All charges over $500 for hair prosthesis*	*All charges*	*All charges*
Durable medical equipment (DME)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
We cover rental or purchase of prescribed durable medical equipment, at our option, including repair and adjustment. Contact Plan at 888-238-6240 for specific covered DME. Some covered items include: • Oxygen • Dialysis equipment • Hospital beds (Clinitron and electric beds must be preauthorized)	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Insulin pumps and related supplies such as needles and catheters • Certain bathroom equipment such as bathtub seats, benches and lifts • Medical foods taken for the treatment of Inborn Errors of Metabolism when provided by a participating DME provider and administered under the direction of a physician Note: Some DME may require precertification by you or your physician.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Home modifications such as stair glides, elevators and wheelchair ramps* • *Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities* • *Elastic stockings and support hose* • *Medical foods that do not require a prescription under Federal law even if your physician or other health care professional prescribes them* • *Nutritional supplements that are not administered by catheter or nasogastric tubes, except for oral medical foods taken for the treatment of Inborn Errors of Metabolism when administered under the direction of a physician* • *Replacement of durable medical equipment, prosthetic devices and corrective appliances unless it is needed because the existing device has become inoperable through normal wear and tear and cannot be repaired, or because of a change in the member's condition*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Home health services	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Home health services ordered by your attending physician and provided by nurses and home health aides through a home health care agency. Home health services include skilled nursing services provided by a licensed nursing professional; services provided by a physical therapist, occupational therapist, or speech therapist; and services of a home health aide when provided in support of the skilled home health services. Home health services are limited to one (1) visit per day with each visit equal to a period of four (4) hours or less. The Plan will allow up to 60 visits per member per calendar year. Your attending physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy. Note: Skilled nursing under Home health services must be precertified by your attending Physician.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Intravenous (IV) Infusion Therapy and medications	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Nursing care for the convenience of the patient or the patient's family.* • *Transportation* • *Custodial care, i.e., home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative, and appropriate for the active treatment of a condition, illness, disease or injury.* • *Services of a social worker* • *Services provided by a family member or resident in the member's home.* • *Services rendered at any site other than the member's home.* • *Private duty nursing services.*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Chiropractic	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
No benefits	All charges	All charges
Alternative medicine treatments	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Acupuncture - 10 visits per member per calendar year (when considered medically necessary) Note: See Section 5(b) for our coverage of acupuncture when provided as anesthesia for covered surgery. See Section 5 Non-FEHB benefits available to Plan members for discount arrangements.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Other alternative medical treatments including but not limited to: • *Acupuncture other than stated above* • *Applied kinesiology* • *Aromatherapy* • *Biofeedback* • *Craniosacral therapy* • *Hair analysis* • *Reflexology*	*All charges*	*All charges*
Educational classes and programs	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Aetna offers disease management. Included are programs for: • Asthma • Cerebrovascular disease • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Coronary artery disease • Cystic Fibrosis • Depression • Diabetes • Hepatitis • Inflammatory bowel disease • Kidney failure • Low back pain • Sickle cell disease To request more information on our disease management programs, call 888-238-6240.	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Educational classes and programs (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Coverage is provided for: • Tobacco cessation Programs, including individual/group/ phone counseling, and for physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence. Note: OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	In-network: Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat nicotine dependence. Out-of-network: Nothing up to our Plan allowance for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing up to our Plan allowance for OTC drugs and prescription drugs approved by the FDA to treat nicotine dependence.	In-network: Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat nicotine dependence. Out-of-network: Nothing up to our Plan allowance for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing up to our Plan allowance for OTC drugs and prescription drugs approved by the FDA to treat nicotine dependence.

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- 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).

Note: Equipment charges for medically necessary intraoperative neurological monitoring (IONM) services furnished in connection with a covered surgery are included in the benefit that the Plan issues to the approved surgical facility. The Plan will not pay IONM equipment charges (known as the "technical component") billed by any other entity. If you are planning a surgery with a non-network surgeon who suggests using a non-participating IONM provider during the procedure, you should confirm that the good faith cost estimate the non-network surgeon furnishes you as required by law does not make you responsible for paying IONM equipment charges billed by a provider other than that approved facility.

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your deductible is $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment in-network and $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment out-of-network. Once an individual meets the Self Only deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section. The deductibles for in-network and out-of-network do not cross apply and will need to be met separately for traditional benefits to begin. **(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible).**
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

*** Note: If you are covered by Medicare Part A and B and it is primary, your out-of-pocket costs for services that both Medicare Part A or B and we cover depend on whether your provider accepts Medicare assignment for the claim.**

- **If your provider accepts Medicare assignment, then you pay nothing for covered charges.**
- **If your provider does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the provider's charge (whichever is less) and our payment combined with Medicare's payment.**

Note: We do not waive benefit limitations. In addition, we do not waive any coinsurance or copayments for prescription drugs.

Benefit Description	You pay After the calendar year deductible...	
(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible)		
Surgical procedures	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Routine 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 severe 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, nonalcoholic steatohepatitis (NASH) or refractory hypertension). * ** - Members must have attempted weight loss in the past without successful long-term weight reduction; and Members must have participated in and been compliant with an intensive multicomponent behavioral intervention through a combination of dietary changes and increased physical activity for 12 or more sessions occurring within 2 years prior to surgery. Blood glucose control must be optimized, and psychological clearance may be necessary. **We will consider:** • Open or laparoscopic Roux-en-Y gastric bypass; or • Open or laparoscopic biliopancreatic diversion with or without duodenal switch; or • Sleeve gastrectomy; or • Laparoscopic adjustable silicone gastric banding (Lap-Band) procedures. • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic *devices* for device coverage information	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Surgical procedures (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
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	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
* Requires Precertification. See Section 3 “Other Services” under “You need prior Plan approval for certain services.” . 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 888-238-6240. ** Subject to medical necessity based on our clinical policy bulletin.	Not applicable.	Not applicable.
Voluntary sterilization for women (e.g., tubal ligation)	Nothing (no deductible)	Nothing (no deductible)
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 Section 5(a) Foot care)*	*All charges*	*All charges*
Reconstructive surgery	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***

• 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.
	In-network: 20% of our Plan allowance
	
	Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
		In-network: 0% of our Plan allowance
		
		Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Reconstructive surgery (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedema - breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form and for which the disfigurement is not associated with functional impairment, except repair of accidental injury See Section 5(d) Accidental injury).* • *Surgery for Sex-Trait Modification to treat gender dysphoria* *If you are mid-treatment under this plan, within a surgical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. You may be eligible for our continuation of care process only if the covered surgical regimen was initiated, with prior approval, before January 1, 2026. Please refer to www. aetnafeds.com/gender-affirming-care.php for additional details, forms and requirements regarding the continuation of care process. If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process.* *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Oral and maxillofacial surgery	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Oral surgical procedures, that are medical in nature, such as: • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ (must be preauthorized); and • Excision of tumors and cysts. Note: When requesting oral and maxillofacial services, please check our online provider directory or call Member Services at 888-238-6240 for a participating oral and maxillofacial surgeon.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Dental implants* • *Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*	*All charges*
Organ/tissue transplants	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***

These **solid organ and tissue 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 in Section 3.
• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis
• Cornea
• Heart
• Heart/lung
• Intestinal transplants
  - Isolated small intestine
  - Small intestine with the liver
  - Small intestine with multiple organs, such as the liver, stomach, and pancreas
• Kidney
• Kidney-pancreas
• Liver
• Lung: single/bilateral/lobar
• Pancreas; Pancreas/Kidney (simultaneous)
	In-network: 20% of our Plan allowance
	
	Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
		In-network: 0% of our Plan allowance
		
		Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - High-risk neuroblastoma - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Blood or marrow stem cell transplants Physicians measure many features of leukemia or lymphoma cells to gain insight into its aggressiveness or likelihood of response to various therapies. Some of these include the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. These analyses may allow physicians to determine which diseases will respond to chemotherapy or which ones will not respond to chemotherapy and may rather respond to transplant. The Plan extends coverage for the diagnoses as indicated below. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)* - Hemoglobinopathy - Hematopoietic Stem Cell Transplant (HSCT) - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
- Marrow Failure and Related Disorders (i.e. Fanconi’s, Paroxysmal Nocturnal Hemoglobinuria, 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 - Breast cancer* - Ependymoblastoma - Epithelial ovarian cancer* - Ewing's sarcoma - Hematopoietic Stem Cell Transplant (HSCT) - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors - Waldenstrom’s macroglobulinemia *Approved clinical trial necessary for coverage.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence.	In-network: 20% of our Plan allowance	In-network: 0% of our Plan allowance

Organ/tissue transplants - continued on next page

<table>
<tr><th rowspan="2">Benefit Description</th><th colspan="2">You pay
After the calendar year deductible...</th></tr>
<tr><th>Aetna Direct</th><th>Aetna Direct with Medicare A & B primary*</th></tr>
<tr><td colspan="3">Organ/tissue transplants (cont.)</td></tr>
<tr><td>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
• Non-myeloablative allogeneic, reduced intensity conditioning or RIC for:
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
- Advanced Hodgkin’s lymphoma
- Advanced non-Hodgkin’s lymphoma
- Breast cancer
- Chronic lymphocytic leukemia
- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)
- Chronic myelogenous leukemia
- Colon cancer
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma
- Multiple myeloma
- Multiple sclerosis
- Myelodysplasia/Myelodysplastic Syndromes
- Myeloproliferative disorders (MPDs)
- Non-small cell lung cancer
- Ovarian cancer
- Prostate cancer
- Renal cell carcinoma
- Sarcomas</td><td>In-network: 20% of our Plan allowance

Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</td><td>In-network: 0% of our Plan allowance

Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.</td></tr>
</table>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
- 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 lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive) - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis **National Transplant Program (NTP) -** Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your primary care doctor and plan specialist physician and approved by our medical director in advance of the surgery. To receive in-network benefits the transplant must be performed at hospitals (Institutes of Excellence) specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• *Note: Transplants must be performed at hospitals designated as Institutes of Excellence (IOE). Hospitals in our network, but not designated as IOE hospitals will be covered at the out-of-network benefit level. • 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.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Clinical trials must meet the following criteria: A. The member has a current diagnosis that will most likely cause death within one (1) 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 (2) 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	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
c. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national cooperative body (e.g., Department of Defense, VA Affairs) and conforms to the rigorous independent oversight criteria as defined by the NCI for the performance of clinical trials; and d. The clinical trial is not a single institution or investigator study (NCI designated Cancer Centers are exempt from this requirement); and 4. The member must: a. Not be treated "off protocol," and b. Must actually be enrolled in the trial.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials. Terminal illness means a medical prognosis of six (6) months or less to live); and* • *Costs of data collection and record keeping that would not be required but for the clinical trial; and* • *Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs"); and* • *Items and services provided by the trial sponsor without charge* • *Donor screening tests and donor search expenses, except as shown* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Professional services (including Acupuncture - when provided as anesthesia for a covered surgery) provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- 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).

Note: Equipment charges for medically necessary intraoperative neurological monitoring (IONM) services furnished in connection with a covered surgery are included in the benefit that the Plan issues to the approved surgical facility. The Plan will not pay IONM equipment charges (known as the “technical component”) billed by any other entity. If you are planning a surgery with a non-network surgeon who suggests using a non-participating IONM provider during the procedure, you should confirm that the good faith cost estimate the non-network surgeon furnishes you as required by law does not make you responsible for paying IONM equipment charges billed by a provider other than that approved facility.

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your deductible is $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment in-network and $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment out-of-network. Once an individual meets the Self Only deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section. The deductibles for in-network and out-of-network do not cross apply and will need to be met separately for traditional benefits to begin. **(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible).**
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR NON-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.
- We define observation as monitoring patients following medical or surgical treatments to find out if they need more care, need admission or can be discharged. Observation care can be billed as Emergency Room, Outpatient, or Inpatient depending on where services are rendered, benefited accordingly and how it is billed to us within the scope of the facilities contract. Hospital observation cost share is determined as anything greater than 23 hours, and Aetna’s policy is to allow up to 48 hours of hospital observation without preauthorization. After 48 hours, facilities must determine if they are going to discharge or admit the patient from observation and if admitting they will be responsible to preauthorize (if out-of-network member is responsible to preauthorize inpatient stay). Once admitted, inpatient member cost sharing will apply.

***Note: If you are covered by Medicare Part A and B and it is primary, your out-of-pocket costs for services that both Medicare Part A or B and we cover depend on whether your provider accepts Medicare assignment for the claim.**

- **If your provider accepts Medicare assignment, then you pay nothing for covered charges.**
- **If your provider does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the provider's charge (whichever is less) and our payment combined with Medicare's payment.**

Note: We do not waive benefit limitations. In addition, we do not waive any coinsurance or copayments for prescription drugs.

Benefit Description	You pay After the calendar year deductible...	
(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible)		
Inpatient hospital	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Room and board, such as • Private, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Whole blood and concentrated red blood cells not replaced by the member* • *Non-covered facilities, such as nursing homes, schools*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Inpatient hospital (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• *Custodial care, rest cures, domiciliary or convalescent cares* • *Personal comfort items, such as phone and television* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • 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: Certain devices require precertification by you or your physician. Please see Section 3 for a list of services that require precertification. Note**:** We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Note: In-network preventive care services are not subject to coinsurance listed.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Whole blood and concentrated red blood cells not replaced by the member.	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Extended care benefits/Skilled nursing care facility benefits	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 60-day limit per calendar year when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Custodial care	*All charges*	*All charges*
Hospice care	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of your attending Physician, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Ambulance	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency*	*All charges*	*All charges*

Ambulance - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Ambulance (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• *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*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your deductible is $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment in-network and $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment out-of-network. Once an individual meets the Self Only deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section. The deductibles for in-network and out-of-network do not cross apply and will need to be met separately for traditional benefits to begin. **(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible).**
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We define observation as monitoring patients following medical or surgical treatments to find out if they need more care, need admission or can be discharged. Observation care can be billed as Emergency Room, Outpatient, or Inpatient depending on where services are rendered, benefited accordingly and how it is billed to us within the scope of the facilities contract. Hospital observation cost share is determined as anything greater than 23 hours, and Aetna’s policy is to allow up to 48 hours of hospital observation without preauthorization. After 48 hours, facilities must determine if they are going to discharge or admit the patient from observation and if admitting they will be responsible to preauthorize (if out-of-network member is responsible to preauthorize inpatient stay). Once admitted, inpatient member cost sharing will apply.

*** Note: If you are covered by Medicare Part A and B and it is primary, your out-of-pocket costs for services that both Medicare Part A or B and we cover depend on whether you provider accepts Medicare assignment for the claim.**

- **If your provider accepts Medicare assignment, then you pay nothing for covered charges.**
- **If your provider does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the provider's charge (whichever is less) and our payment combined with Medicare's payment.**

Note: We do not waive benefit limitations. In addition, we do not waive any coinsurance or copayments for prescription drugs.

What is a medical emergency?

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

What to do in case of emergency:

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

Benefit Description	You pay After the calendar year deductible...	
(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible)		
Emergency	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Emergency or urgent care at a doctor's office • Emergency or urgent care at an urgent care center • Emergency care as an outpatient (Emergency Room) in a hospital, including doctors' services	In-network: 20% of our Plan allowance Out-of-network: 20% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Telehealth services	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Teladoc Health consult	In-network: 20% of the consult fee Out-of-network: No benefit. Must use Teladoc Health provider.	In-network: 0% per consult Out-of-network: No benefit. Must use Teladoc Health provider.
• CVS Health Virtual Care™	In-network: $55 per consult until the deductible is met, $0 per consult after deductible has been met Out-of-network: Not available	In-network: $0 per consult Out-of-network: Not available
Please see www. aetnafeds.com/tools/php for information on medical and behavioral telehealth services. Members will receive a welcome kit explaining the telehealth benefits.	Please see www. aetnafeds. com/tools/php for information on medical and behavioral telehealth services.	Please see www. aetnafeds. com/tools/php for information on medical and behavioral telehealth services.
Ambulance	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
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	In-network: 20% of our Plan allowance Out-of-network: 20% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Ambulance - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Ambulance (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member. Note: Air ambulance may be covered. Prior approval is required.	In-network: 20% of our Plan allowance Out-of-network: 20% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency.* • *Ambulette service.* • *Air ambulance without prior approval.* • *Ambulance transportation for member convenience or for reasons that are not medically necessary.* *Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.*	*All charges*	*All charges*

Section 5(e). Mental health and Substance Use Disorder Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins. Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Your deductible is $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment in-network and $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment out-of-network. Once an individual meets the Self Only deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section. The deductibles for in-network and out-of-network do not cross apply and will need to be met separately for traditional benefits to begin. **(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible).**
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. Please see Section 3 of this brochure for a list of services that require preauthorization.
- 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 888-238-6240. A referral from your PCP is not necessary to access behavioral health care but your PCP may assist in coordinating your care.
- We will provide medical review criteria or reasons 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.

***Note: If you are covered by Medicare Part A and B and it is primary, your out-of-pocket costs for services that both Medicare Part A or B and we cover depend on whether your provider accepts Medicare assignment for the claim.**

- **If your provider accepts Medicare assignment, then you pay nothing for covered charges.**
- **If your provider does not accept Medicare assignment, then you pay the difference between the "limiting charge" or the provider's charge (whichever is less) and our payment combined with Medicare's payment.**

Note: We do not waive benefit limitations. In addition, we do not waive any coinsurance or copayments for prescription drugs.

Benefit Description	You pay After the calendar year deductible...	
(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible)		
Professional services	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Psychiatric office visits to Behavioral Health practitioner • Substance Use Disorder (SUD) office visits to Behavioral Health practitioner • Routine psychiatric office visits to Behavioral Health practitioner • Behavioral therapy	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Telehealth Behavioral Health consult	In-network: 20% of our Plan allowance Out-of-network: Not covered	In-network: 20% of our Plan allowance Out-of-network: Not covered
CVS Health Virtual Care™ telehealth consult	In-network: 20% of our Plan allowance Out-of-network: Not available	In-network: 0% of our Plan allowance Out-of-network: Not available
Skilled behavioral health services provided in the home, but only when all of the following criteria are met: • The services are ordered by a physician or independently licensed behavioral health professional (BHP) and are directly related to an active treatment plan of care established by the physician or licensed BHP; and • Care is appropriate for the active treatment of a condition, illness or disease; and • Care is intermittent or hourly in nature*; and • Care is provided under the supervision of an independently licensed BHP; and • Services take the place of a stay in a hospital or residential treatment facility (RTF), or receiving outpatient services outside of the home; and • Treatment provided is appropriate for the member's condition including the amount of time spent providing the service as well as the frequency, type and duration of the services; and • Services provided are not primarily for the comfort or convenience of the member or family or custodial in nature **.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Professional services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Professional services (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
* Intermittent or part-time skilled home behavioral health care is defined as a visit of up to 1 hour in duration. ** Custodial care is defined as services and supplies furnished to a person mainly to help him or her with activities of daily living. Custodial care includes services and supplies: - Furnished mainly to train or assist the insured family member in personal hygiene and other activities of daily living rather than to provide therapeutic treatment; or - That can be safely and adequately provided by persons without the technical skills of a health care provider (e.g., nurse).	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Applied Behavior Analysis (ABA) We cover medically necessary Applied Behavior Analysis (ABA) therapy when provided by network behavioral health providers. These providers include: • Providers who are licensed or who possess a state-issued or state-sanctioned certification in ABA therapy. • Behavior analysts certified by the Behavior Analyst Certification Board (BACB). • Registered Behavior Technicians (RBTs) certified by the BACB or equivalent paraprofessionals who work under the supervision of a licensed provider or a certified behavior analyst. Note: Requires Precertification. See “Other Services” under “You need prior Plan approval for certain services" in Section 3. 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 888-238-6240.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount
Diagnostics	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• Psychological and Neuropsychological testing provided and billed by a licensed mental health and SUD treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible...	
Inpatient hospital or other covered facility	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Inpatient services provided and billed by a hospital or other covered facility including an overnight residential treatment facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Outpatient hospital or other covered facility	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
Outpatient services provided and billed by a hospital or other covered facility including other outpatient mental health treatment such as: • Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician • Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician • Outpatient detoxification • Ambulatory detoxification which is outpatient services that monitor withdrawal from alcohol or other substance use, including administration of medications • Electro-convulsive therapy (ECT) • Transcranial magnetic stimulation (TMS) • Psychological/Neuropsychological testing	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
• *Educational services for treatment of behavioral disorders* • *Services in half-way houses*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- This is a five tier open formulary pharmacy plan, Advanced Control Formulary. The Formulary is a list of drugs that your health plan covers. With your Advanced Control Formulary Pharmacy plan, each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Each tier has a separate out-of-pocket cost.
  - Preferred generic
  - Preferred brand
  - Non-preferred generic and brand
  - Preferred specialty
  - Non-preferred specialty
- We cover prescribed drugs and medications, as described in the chart beginning on the third page. Copayment/coinsurance levels reflect in-network pharmacies only. If you obtain your prescription at an out-of-network pharmacy (non-preferred), you will be reimbursed at our Plan allowance less 50%. You are responsible for any difference between our Plan allowance and the billed amount.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Federal law prevents the pharmacy from accepting unused medications.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- For prescription drugs and medications, you first must satisfy your deductible: $1,600 for Self Only enrollment, $3,200 for Self Plus One enrollment and $3,200 for Self and Family enrollment in-network and $1,600 for Self Only, $3,200 for Self Plus One and $3,200 for Self and Family enrollment out-of-network each calendar year. Once an individual meets the Self Only deductible under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical benefits. The remaining balance of the Self Plus One and Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section. The cost of your prescription is based on our contracted rate with network pharmacies. The deductibles for in-network and out-of-network do not cross apply and will need to be met separately for traditional benefits to begin. **(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible).**
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Plan begins. Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Once you satisfy the deductible, you will then pay a copayment or coinsurance at in-network retail pharmacies or the mail-order pharmacy for prescriptions under your Traditional medical coverage. You will pay 50% coinsurance plus the difference between our Plan allowance and the billed amount at out-of-network retail pharmacies. There is no out-of-network mail order pharmacy program.
- Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Upon approval by the Plan, the prescription is covered for the current calendar year or a specified time period, whichever is less.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

- The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). We do not exclude coverage for entire classes of pharmaceuticals, e.g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.
- *** Note: If you are enrolled in the Aetna Direct option and are covered by Medicare and it is primary, we will automatically enroll you in our Employer Group Waiver Plan (EGWP) Prescription Drug Plan (PDP) under Medicare Part D. This EGWP PDP enhances your FEHB coverage by offering lower cost shares on the prescription tiers for covered drugs. Participants will receive a separate Aetna Medicare RX® offered by SilverScript®prescription ID card to use for filling prescriptions. You can find more details at the end of this section and Section 9 Medicare prescription drug coverage (Part D). The PDP is subject to Medicare rules.**
- **See Section 9 for the PDP EGWP opt out process.**
- If you remain enrolled in our EGWP PDP under Medicare Part D, your cost share will no longer automatically pay from the Medical fund. You can still use the fund, just submit your receipts to us for reimbursement. You can find the form at https://aetnafeds.com/resources.php.

Note: We do not waive benefit limitations. In addition, we do not waive any coinsurance or copayments for prescription drugs.

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

- **Who can write your prescription.** A licensed physician or dentist or, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.
- **Where you can obtain them.** Any retail pharmacy can be used for up to a 30-day supply. Our mail order program must be utilized for a 31-day up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay (retail pharmacy), and for a 31-day up to a 90-day supply of medication for two copays (mail order). For retail pharmacy transactions, you must present your Aetna Member ID card at the point of sale for coverage. Please call Member Services at 888-238-6240 for more details on how to use the mail order program. **Mail order is not available for drugs and medications ordered through a network Specialty Pharmacy. Prescriptions ordered through a network Specialty Pharmacy are only filled for up to a 30-day supply due to the nature of these prescriptions.** If accessing a nonparticipating pharmacy, the member must pay the full cost of the medication at the point of service, then submit a complete paper claim and a receipt for the cost of the prescription to our Direct Member Reimbursement (DMR) unit. Reimbursements are subject to review to determine if the claim meets applicable requirements, and are subject to the terms and conditions of the benefit plan and applicable law.
- **We have an open managed formulary.** The formulary is a list of drugs that your Plan covers. Drugs are prescribed by attending licensed doctors and covered in accordance with the Pharmacy Drug (Formulary) Guide. Certain drugs require your doctor to get precertification or step therapy from the Plan before they can be covered under the Plan. Your prescription drug plan includes drugs listed in the Pharmacy Drug (Formulary) Guide. Prescription drugs listed on the formulary exclusions list are excluded unless a medical exception is approved by the Plan. If it is medically necessary for you to use a prescription drug on the Formulary Exclusions List, you or your prescriber must request a medical exception. Please see our online formulary and drug pricing search tools at the following www. aetnafeds.com/pharmacy.php or call us at 888-238-6240.
- **Drugs not on the formulary.** Formularies are developed and reviewed by the CVS Caremark 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 and safety 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 the Plan to re-evaluate the generic for possible inclusion on the formulary. We will place some of these generic drugs that are granted a period of exclusivity on our non-formulary list, which requires the highest copay level.

- **Choose generics.** The Plan requires the use of generics if a generic drug is available. If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance* unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained from the Plan. Generics contain the same active ingredients in the same amounts as their brand name counterparts and have been approved by the FDA. By using generic drugs, you will see cost savings, without jeopardizing clinical outcome or compromising quality. * The differential/penalty will not apply to Plan accumulators (example: deductible and out-of-pocket maximum)
- **Precertification.** Your pharmacy benefits plan includes precertification. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-approved 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 precertification for a drug. Step-therapy is another type of precertification. Certain medications will be excluded from coverage unless you try one or more "step" drug(s) first, or unless a medical exception is obtained. The drugs requiring precertification or step-therapy are subject to change. Visit our website at www. aetnafeds.com for the most current information regarding the precertification and step-therapy lists. Ask your physician if the drugs being prescribed for you require precertification or step therapy.
- **When to use a participating retail or mail order pharmacy.** Covered prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy may be dispensed for up to a 30-day supply. Members must obtain a 31-day up to a 90-day supply of covered prescription medication through mail order. In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available. (See choose generics above) While mail order is most likely the most cost effective option for most prescriptions, there may be some instances where the most cost effective option for members will be to utilize a retail pharmacy for a 30 day supply versus mail order. Members should utilize the Cost of Care Tool on the Aetna Member website prior to ordering prescriptions through mail order to determine the cost.

  In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filing of their medication(s) prior to departure, their pharmacist will need to contact Aetna. Coverage of additional prescriptions will only be allowed if there are refills remaining on the member's current prescription or a new prescription has been issued by their physician. The member is responsible for the applicable copayment for the additional prescription.
- The Plan allows coverage of a medication refill when at least 80% of the previous prescription according to the physician’s prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a prescription refill to be covered 24 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, 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.
- **Mail order pharmacy**. Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Outpatient prescription drugs are covered when dispensed by a network mail order pharmacy or a CVS pharmacy®. Each prescription is limited to a maximum 90-day supply. Prescriptions for less than a 30-day supply or more than a 90-day supply are not eligible for coverage when dispensed by a network mail order pharmacy.

- **Specialty drugs.** Specialty drugs are medications that treat complex, chronic diseases, which includes select oral, injectable and infused medications. The first fill including all subsequent refills of these medications must be obtained through a participating network pharmacy.

  Certain Specialty Formulary medications identified on the Specialty Drug List 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 network 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. For a detailed listing of specialty medications visit www.aetnafeds.com/pharmacy.php or contact us at 888-238-6240 for a copy. Note that the medications and categories covered are subject to change. **Some specialty medications may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, you shall not receive credit toward your out-of-pocket maximum or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate. (Note: If you have Medical Funds available, the fund will be used until no funds are available before copay assistance or other third-party copay assistance can be applied to benefits)**

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

Benefit Description	You pay After the calendar year deductible...
(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible).	
Covered medications and supplies	**Aetna Direct**
We cover the following medications and supplies prescribed by your licensed attending physician or dentist and obtained from a Plan pharmacy or through our mail order program or an out-of-network retail pharmacy: • Drugs and medications approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as Not covered • Self-injectable drugs • Diabetic supplies limited to: - Lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips - Insulin - Disposable needles and syringes for the administration of covered medications • Prenatal vitamins (as covered under the Plan's formulary) • Medications prescribed to treat obesity • Oral and Injectable Infertility medications (includes Artificial Insemination (AI), In vitro fertilization (IVF)/ART medications) (Limited to $25,000 per member per calendar year)	**In-network:** The full cost of the prescription is applied to the deductible before any benefits are considered for payment under the pharmacy plan. Once the deductible is satisfied, the following will apply: (Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible). Retail Pharmacy, for up to a 30-day supply per prescription or refill: $6 per Preferred Generic (PG) formulary drug; 30% per Preferred Brand (PB) name formulary drug up to a $600 maximum; and 50% per covered Non-Preferred (NP) (generic or brand name) drug up to a $600 maximum. Mail Order Pharmacy or CVS Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $2 per Preferred Generic (PG) formulary drug; and 30% up to $100 maximum per Preferred Brand (PB) name formulary drug; and 50% up to $200 maximum per covered Non-Preferred (NP) (generic or brand name) drug.

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	**Aetna Direct**
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. Note: Certain drugs to treat infertility are considered specialty drugs. Please see Specialty drugs in this section. Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat nicotine dependence are covered under the Tobacco cessation program. (See Section 5(a)). OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	**In-network:** The full cost of the prescription is applied to the deductible before any benefits are considered for payment under the pharmacy plan. Once the deductible is satisfied, the following will apply: (Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible). Retail Pharmacy, for up to a 30-day supply per prescription or refill: $6 per Preferred Generic (PG) formulary drug; 30% per Preferred Brand (PB) name formulary drug up to a $600 maximum; and 50% per covered Non-Preferred (NP) (generic or brand name) drug up to a $600 maximum. Mail Order Pharmacy or CVS Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $2 per Preferred Generic (PG) formulary drug; and 30% up to $100 maximum per Preferred Brand (PB) name formulary drug; and 50% up to $200 maximum per covered Non-Preferred (NP) (generic or brand name) drug. **Out-of-network (retail pharmacies only):** 50% plus the difference between our Plan allowance and the billed amount.
Contraceptive drugs and devices as listed in the Health Resources and Services Administration ACA/HRSA site www. hrsa.gov/ womens-guidelines. Contraceptive coverage is available at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Visit www. aetnafeds.com/familyplanning.php for more information on contraception and the the exception process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7.	See coverage below

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	**Aetna Direct**
Note: If it is medically necessary for you to use a prescription drug on the Formulary Exclusions List, you or your prescriber must request a medical exception. Visit our website at www. aetnafeds. com/pharmacy.php to review our Pharmacy Drug (Formulary) Guide or call 888-238-6240.	See coverage below
Women's contraceptive drugs and devices • Generic oral contraceptives on our formulary list • Generic injectable contraceptives on our formulary list - five (5) vials per calendar year • Generic emergency contraception, including over-the-counter (OTC) when filled with a prescription • Diaphragms - one (1) per calendar year • Brand name Intra Uterine Device • Generic patch contraception	**In-network:** Nothing **Out-of-network (retail pharmacies only):** 50% plus the difference between our Plan allowance and the billed amount.
• Brand name contraceptive drugs • Brand name injectable contraceptive drugs such as Depo Provera - five (5) vials per calendar year • Brand emergency contraception Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	Retail Pharmacy, for up to a 30-day supply per prescription or refill: 30% per Preferred Brand (PB) name formulary drug up to a $600 maximum; and 50% per covered Non-Preferred (NP) (generic or brand name) drug up to a $600 maximum. Mail Order Pharmacy or CVS Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: 30% up to $100 maximum per Preferred Brand (PB) name formulary drug; and 50% up to $200 maximum per covered Non-Preferred (NP) (generic or brand name) drug. **Out-of-network (retail pharmacies only):** 50% plus the difference between our Plan allowance and the billed amount.
Specialty Medications **Specialty medications must be filled through a network specialty pharmacy.** These medications are not available through the mail order benefit. Certain Specialty Formulary medications identified on the Specialty Drug List may be covered under the medical or pharmacy section of this brochure. Please refer to above, Specialty Drugs for more information or visit: www. aetnafeds.com/pharmacy.php.	Up to a 30-day supply per prescription or refill: Preferred Specialty (PSP): 50% up to $600 maximum Non-preferred Specialty (NPSP): 50% up to $1,200 maximum
Limited benefits: • Drugs to treat erectile dysfunction are limited up to six (6) tablets per 30-day period.	**In-network:** Retail Pharmacy, for up to a 30-day supply per prescription or refill: $6 per Preferred Generic (PG) formulary drug;

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies (cont.)	**Aetna Direct**
	30% up to $600 maximum per Preferred Brand (PB) name formulary drug; and 50% up to $600 maximum per covered Non-Preferred (NP) (generic or brand name) drug. **Out-of-network** (retail pharmacies only)**:** 50% plus the difference between our Plan allowance and the billed amount.
Preventive care medications	**Aetna Direct**
Medications to promote better health as recommended by ACA. Drugs and supplements are covered without cost-share which includes over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. We will cover preventive medications in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations/ guidance: • Aspirin • Folic acid supplements • Oral Fluoride • Statins • Breast Cancer Prevention drugs • HIV PrEP • Nicotine Replacement Medications (Limits apply) • Bowel Prep Medications (Required with preventive Colonoscopy) Opioid rescue agents are covered under this Plan with no cost sharing when obtained from an in-network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at: www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www. findtreatment.samhsa.gov/ Please refer to the formulary guide for a complete list of preventive drugs including coverage details and limitations: www. aetnafeds.com/pharmacy.php. Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. For current recommendations go to www. uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.	**In-network**: Nothing

Preventive care medications - continued on next page

Benefit Description	You pay After the calendar year deductible...
Preventive care medications (cont.)	**Aetna Direct**
Not covered: • *Drugs for cosmetic purposes, such as Rogaine* • *Drugs to enhance athletic performance* • *Nonprescription medications unless specifically indicated elsewhere* • *Medical supplies such as dressings and antiseptics* • *Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug) unless required by law or covered by the plan.* • *Lost, stolen or damaged drugs* • *Vitamins (including prescription vitamins), nutritional supplements, and any food item, including infant formula, medical foods and other nutritional items not listed as a covered benefit, even if it is the sole source of nutrition unless otherwise stated.* • *Prophylactic drugs including, but not limited to, anti-malarials for travel* • *Compounded bioidentical hormone replacement (BHR) therapy that includes progesterone, testosterone and/or estrogen.* • *Compounded thyroid hormone therapy* • *Drugs prescribed in connection with Sex-Trait Modification for treatment of gender dysphoria* *If you are mid-treatment under this plan, within a chemical regimen for Sex-Trait Modification for diagnosed gender dysphoria, for services for which you received coverage under the 2025 Plan brochure, you may seek an exception to continue care for that treatment. You may be eligible for our continuation of care process only if the covered chemical regimen was initiated, with prior approval, before January 1, 2026. Please refer to www.aetnafeds.com/gender-affirming-care.php for additional details, forms and requirements regarding the continuation of care process. If you disagree with our decision on your exception, please see Section 8 of this brochure for the disputed claims process.* *Individuals under age 19 are not eligible for exceptions related to services for ongoing surgical or hormonal treatment for diagnosed gender dysphoria.*	*All charges*

Benefit Description	
(Note: Deductible does not apply to the below Rx benefit)	
Medicare Part D Prescription Drug Plan - EGWP PDP Aetna Medicare RX® offered by SilverScript®	**Aetna Direct**
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: This prescription drug plan offers the Comprehensive Plus formulary which covers all drugs that CMS determines to be Part D and additionally, offers supplemental benefits for coverage of non-Part D drugs as outlined below. For access to our formulary, please visit: www. aetnafeds.com/pharmacy Non-Part D Supplemental Benefit: • Agents used for cosmetic purposes or hair growth. • Agents used to promote fertility. • Agents when used for the symptomatic relief of cough and colds. • Agents when used for the treatment of sexual or erectile dysfunction (ED). • Agents when used for weight loss. • Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations. • Part B drugs.	Retail Pharmacy, for up to a 30-day supply per prescription or refill: • Tier 1 Preferred Generic: $0 per drug at preferred/ standard pharmacy; • Tier 2 Generic: $1 per drug at preferred pharmacy; $2 per drug at standard pharmacy; • Tier 3 Preferred Brand: $45 per drug at preferred/ standard pharmacy; • Tier 4 Non-Preferred Brand: $75 per drug at preferred/standard pharmacy; • Tier 5 Specialty (Includes high-cost/unique generic and brand drugs): 25%, but not more than $250 per drug at preferred/standard pharmacy; Retail/Mail Order Pharmacy, for up to a 90-day supply per prescription or refill: • Tier 1 Preferred Generic: $0 per drug at preferred/ standard pharmacy; • Tier 2 Generic: $2 per drug at preferred pharmacy; $4 per drug at standard pharmacy; • Tier 3 Preferred Brand: $75 per drug at preferred/ standard pharmacy; • Tier 4 Non-Preferred Brand: $125 per drug at preferred/standard pharmacy; • Tier 5 Specialty: only available for 30 day supply
• Preventive drugs that are part of the Affordable Care Act. A valid prescription is required. • Narcan • Select drugs to treat cancer • Includes coverage of Part B covered diabetic supplies and vaccines • Tobacco Cessation drugs	$0
Medicare Part D Prescription Drug Plan – EGWP PDP includes a maximum out of pocket. Note: Once you reach the $2,000 out of pocket maximum for your prescription costs, you will pay $0 for the remainder of the calendar year for covered drugs under this Medicare Part D Prescription Drug Plan. This $2,000 will also apply to the Medical Plan’s total calendar year out-of-pocket maximum, see Section 4 for additional details on your Plan option out of pocket maximum.	$2,000

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

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

Benefit Description	You Pay After the calendar year deductible...	
(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible).		
Accidental injury benefit	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount
Dental benefits	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***
We have no other dental benefits.	No coverage	No coverage

Section 5(h). Wellness and Other Special Features

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

Feature	Description
Services for the deaf and hearing-impaired	800-628-3323
National Medical Excellence Program	National Medical Excellence Program helps eligible members access appropriate, covered treatment for solid organ and tissue transplants using our Institutes of Excellence™ network. We coordinate specialized treatment needed by members with certain rare or complicated conditions and assist members who are admitted to a hospital for emergency medical care when they are traveling temporarily outside of the United States. Services under this program must be preauthorized. Contact member services at 888-238-6240 for more information.

Section 5(i). Health Education Resources and Account Management Tools

Special features	Description
Enhanced Maternity Program	Learn about what to expect before and after delivery, early labor symptoms, newborn care and more. We can also help you make choices for a healthy pregnancy, lower your risk for early labor, cope with postpartum depression and stop smoking. We will ask you questions to help us know you better and support you best. Enroll early and receive a reward when you sign up by the 16th week of pregnancy. To enroll in the program, call toll-free 1-800-272-3531 between 8 am and 7 pm ET.
Health education resources	We keep you informed on a variety of issues related to your good health. Visit our website at www.aetnafeds.com or call Member Services at 888-238-6240 for information on: • Aetna Member website • Healthwise® Knowledge base • 24-Hour Nurse Line • Hospital comparison tool and Estimate the Cost of Care tool • Online provider directory • Medical and Dental cost of care tools
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through the Aetna Member website. You can access the Aetna Member website at www.aetnafeds.com. • Your balance will also be shown on your explanation of benefits (EOB) form. • You will receive an EOB after every claim.
Consumer choice information	• As a member of this HDHP, you may choose any licensed provider. However, you will receive discounts when you see a network provider. Directories are available online by going to Aetna Member website at www.aetnafeds.com • Pricing information for medical care is available at www.aetnafeds.com • Pricing information for prescription drugs is available at www.aetnafeds.com • Link to online pharmacy through www.aetnafeds.com • Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.aetnafeds.com
Care support	Patient safety information is available online at www.aetnafeds.com

Non-FEHB Benefits Available to Plan Members

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

Eyewear and exams

Discounts on designer frames, prescription lenses, lens options like scratch coating, tint and non-disposable contact lenses. Save on LASIK laser eye surgery and replacement contact lenses delivered to your door. Save on accessories like eyeglass chains, lens cases, cleaners, and nonprescription sunglasses. Visit many doctors in private practice. Plus, national chains like LensCrafters®, Target Optical® and Pearle Vision®.

Hearing aids and exams

Save on hearing exams, a large choice of leading brand hearing aids, batteries and free routine follow-up services. There are two ways for you to save at thousands of locations through Hearing Care Solutions or Amplifon Hearing Health Care.

Healthy lifestyle choices

Save on gym memberships, health coaching, fitness gear and nutrition products that support a healthy lifestyle. Get access to local and national discounts on brands you know. At-home weight-loss programs with tips and menus. Also save on wearable fitness devices, meditation, yoga, wellness programs and group fitness on demand.

Natural products and services

Ease your stress and tension and save on therapeutic massage, acupuncture or chiropractic care. Get advice from registered dietitians with nutrition services. Save on popular products from health and fitness vendors, like blood pressure monitors, pedometers and activity trackers, devices for pain relief and many other products. Save on teeth whitening, electronic toothbrushes, replacement brush heads and various oral health care kits.

Getting started is easy, just log in to your member website at www. Aetnafeds.com, once you're an Aetna member.

DISCOUNT OFFERS ARE NOT INSURANCE. *They are not benefits under your insurance plan. You get access to discounts off the regular charge on products and services offered by third party vendors and providers. Aetna makes no payment to the third parties--you are responsible for the full cost. Check any insurance plan benefits you have before using these discount offers, as those benefits may give you lower costs than these discounts.*

Discount vendors and providers are not agents of Aetna and are solely responsible for the products and services they provide. Discount offers are not guaranteed and may be ended at any time. Aetna may get a fee when you buy these discounted products and services.

Hearing products and services are provided by Hearing Care Solutions and Amplifon Hearing Health Care.

Vision care providers are contracted through EyeMed Vision Care. LASIK surgery discounts are offered by the U.S. Laser Network and Qualsight. Natural products and services are offered through ChooseHealthy®, a program provided by ChooseHealthy, Inc. which is a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a registered trademark of ASH and is used with permission.

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 “Other Services” under “You need prior Plan approval for certain services."

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Procedures, services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies you receive from a provider or facility barred or precluded 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.
- Services provided by a family member or resident in the member’s home.
- Services or supplies we are prohibited from covering under the Federal law.
- Any benefits or services required solely for your employment are not covered by this plan.
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include “gender transition” services), other than mid-treatment exceptions, see Section 3. How You Get Care.

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 providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims.

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

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

Medical, hospital, and prescription drug benefits

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

In most cases, providers and facilities file HIPAA compliance electronic claims for you. In cases where a paper claim must be used, the provider 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 888-238-6240, or at our website at www.aetnafeds.com.

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

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

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

In addition:

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

Records	Keep a separate record of the medical expenses of each covered family member. Save copies of all medical bills, including those you accumulate to satisfy your deductible. In most instances, they will serve as evidence of your claim. We will not provide duplicate or year-end statements.
Deadline for filing your claim	Send us all of the documents for your claim as soon as possible: Aetna Life Insurance Company P.O. Box 14079 Lexington, KY 40512-4079 Any withdrawals from your HSA must be done via your debit card, check, or Auto-Debit. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.
Overseas claims	For covered services you receive in hospitals outside the United States and performed by physicians outside the United States, send a completed Claim Form and the itemized bills to the following address. Also send any written inquiries, concerning the processing of overseas claims to: Aetna Life Insurance Company P.O. Box 14079 Lexington, KY 40512-4079
Post-service claims procedures	We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected. If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.
Authorized Representative	You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this Section, we are also referring to your authorized representative when we refer to you.
Notice Requirements	If you live in a county where at least 10% 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 phone 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.
Records	Keep a separate record of the medical expenses of each covered family member. Save copies of all medical bills, including those you accumulate to satisfy your deductible. In most instances, they will serve as evidence of your claim. We will not provide duplicate or year-end statements.
When we need more information	Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

Section 8. The Disputed Claims Process

You may appeal to the U.S. Office of Personnel Management (OPM) if we do not follow the required claims process. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Section 3, 7, and 8 of this brochure, please call Aetna's Customer Service at the phone number found on your ID card, plan brochure or plan website: www. aetnafeds.com.

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

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

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

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

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

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 888-238-6240. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 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 family member 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 our website at www.aetnafeds.com/NAIC.php.

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

When we are the secondary payor, the primary Plan will process the benefit for the expenses first, up to its plan limit. If the expense is covered in full by the primary plan, we will not pay anything. If the expense is not covered in full by the primary plan, we determine our allowance. If the primary Plan uses a preferred provider arrangement, we use the lesser of the primary plan's negotiated fee, Aetna's Reasonable and Customary (R&C) and billed charges. If the primary plan does not use a preferred provider arrangement, we use the lesser of Aetna's R&C and billed charges. If the primary plan uses a preferred provider arrangement and Aetna does not, the allowable amount is the lesser of the primary plan's negotiated rate, Aetna's R&C and billed charges. If both plans do not use a preferred provider arrangement, we use the lesser of Aetna's R&C and billed charges.

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. **Note:** When you have Aetna Direct plan option and are covered by Medicare Part A and B and it is primary, your out-of-pocket costs for services that both Medicare Part A or B and we cover depend on whether your provider accepts Medicare assignment for the claim. (See Section 5 for details)

- **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 or employing 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**

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers' Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCFA-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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.

- **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 or employing office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the state program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

This Plan always pays secondary to:

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

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

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

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

Note: If the Plan recovers money through subrogation, the Medical Fund will not be reimbursed.

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.gov or by phone 877-888-3337 (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Recovery rights related to Workers' Compensation

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

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

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

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

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

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

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

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

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

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

Clinical trials

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

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan. See Section 5(b).
- 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 Section 5(b).
- 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 Section 5(b).

When you have Medicare

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

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

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

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

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

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

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

We do not waive any costs if the Original Medicare Plan is your primary payor, unless, you are enrolled in the Aetna Direct Plan and are enrolled in Medicare Part A and B and Medicare is primary. Details on this Plan are outlined in Section 5 of this brochure.

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

Aetna Direct Plan:

You can find more information about how our plan coordinates benefits with Medicare by calling 888-238-6240.

Benefit Description: Deductible
Aetna Direct Option: You pay **without** Medicare**: $1,600 Self Only/$3,200 Self Plus One or Self and Family**
Aetna Direct Option: You pay **with** Medicare Parts A and B (primary)**: $0**

Benefit Description: Part B Premium Reimbursement Offered
Aetna Direct Option: NA
Aetna Direct Option: You pay **with** Medicare Parts A and B (primary)**: $900 Self Only/ $1,800 Self Plus One or Self and Family**

Benefit Description: Primary Care Provider
Aetna Direct Option: You pay **without** Medicare**: 20% of Plan allowance**
Aetna Direct Option: You pay **with** Medicare Parts A and B (primary)**:0%**

Benefit Description: Specialist
Aetna Direct Option: You pay **without** Medicare**: 20% of Plan allowance**
Aetna Direct Option: You pay **with** Medicare Parts A and B (primary): **0%**

Benefit Description: In-Patient Hospital
Aetna Direct Option: You pay **without** Medicare: **20% of Plan allowance**
Aetna Direct Option: You pay **with** Medicare Parts A and B (primary): **0%**

Benefit Description: Out-Patient Hospital
Aetna Direct Option: You pay **without** Medicare: **$20% of Plan allowance**
Aetna Direct Option: You pay **with** Medicare Parts A and B (primary)**: $0**

Benefit Description: Incentives Offered
Aetna Direct Option: You pay **without** Medicare: **NA**
Aetna Direct Option: You pay **with** Medicare Parts A and B (primary)**: Seamless coordination with Medicare and hearing aid discount**

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

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare. **NOTE: It is important that you tell us about your Medicare coverage or other coverage so that your plan benefits can be coordinated.**

- **Medicare Advantage (Part C)**

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

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

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

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage Plan and also remain enrolled in our FEHB Plan. If you are an annuitant or former spouse with FEHBP coverage and are enrolled in Medicare Parts A and B, you may enroll in our Medicare Advantage plan if one is available in your area. **We do not waive cost-sharing for your FEHB coverage.**

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

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

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

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. For more information, please call us at 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. **Note: You cannot have two Part D plans at the same time.** If you are currently enrolled in an individual Medicare Part D Plan and choose to auto enroll or later opt-in to the Aetna Direct option EGWP PDP (Aetna Medicare RX® offered by SilverScript®), you will be disenrolled from your individual Medicare Part D Plan.

- **Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)**

Under the Aetna Direct Plan, we offer a Medicare Employer Group Waiver Plan (EGWP) Prescription Drug Plan (PDP) to Medicare-eligible annuitants and Medicare eligible family members covered under the Plan. The EGWP PDP is a Medicare Part D plan and is actuarially equal to or better than the Aetna Direct prescription drug benefits, meaning you will generally pay less for prescription drugs. Covered drugs will be subject to the formulary approved by the Centers for Medicare and Medicaid Services.

If you are an annuitant or an annuitant's family member who is enrolled in either Medicare Part A or B or Parts A and B, you will be automatically enrolled in the EGWP PDP on January 1, 2026 or later upon becoming Medicare-eligible. There is no need for you or your eligible dependent to take action to enroll. If you do not wish to enroll in the EGWP PDP, you may "opt-out" of the enrollment by following the instructions mailed to you. You will have 21 days to contact us at the toll-free number (833-271-9775) to decline Part D coverage. Declining coverage or "opting out" will place you back into your FEHB prescription drug coverage. Additionally, participation in the PDP EGWP is voluntary, and members can continue to opt out at any time. If you opt out after the first of the month, it will be effective the first of the following month.

We will pay the Medicare premium for this Part D drug plan coverage except any additional premium imposed due to exceeding the income threshold as defined by the Social Security Administration such as Income-Related Monthly Adjustment Amount (IRMAA). IRMAA is an extra amount that you pay in addition to your FEHB premium for your monthly Medicare Part D prescription drug plan premiums and your monthly Medicare Part B premiums. Social Security makes this determination based on your income. This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return. You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans, to see if you would be subject to this additional premium.

Please see Section 5(f) for additional details regarding the EGWP PDP. Below is a side by side comparison of the FEHB prescription drug coverage compared to the EGWP PDP plan that is offered through Aetna Medicare RX® offered by SilverScript® for this Plan.

Benefit Description	You pay	
Covered medications and supplies for up to a 30 day supply	**Aetna FEHB Prescription Benefits - Aetna Direct**	**Medicare Part D Prescription Drug Plan (Aetna Medicare Rx offered by SilverScript)**
Preferred Generic	$6	$0
Generic (includes non-preferred generic)	50% up to $600	$1 preferred pharmacy/ $2 standard pharmacy
Preferred Brand	30% up to $600	$45
Non-preferred Brand	50% up to $600	$75
Specialty Drugs	• 50% up to $600 (preferred specialty) • 50% up to $1,200 (non-preferred specialty)	25% up to $250

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		✔ *
9) Are a Federal employee receiving 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

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

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

Catastrophic Protection

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

HDHP:

Self Only:

In-network: Your annual out-of-pocket maximum is $6,900.

Out-of-network: Your annual out-of-pocket maximum is $9,000.

Self Plus One:

In-network: Your annual out-of-pocket maximum is $13,800.

Out-of-network: Your annual out-of-pocket maximum is $18,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is $13,800.

Out-of-network: Your annual out-of-pocket maximum is $18,000.

Once an individual meets the Self Only out-of-pocket maximum under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical expenses at 100%. The remaining balance of the Self Plus One or Self and Family out-of-pocket maximum can be satisfied by one or more family members. In-network and Out-of-network out-of-pocket maximums do not cross apply and will need to be met separately in order for eligible medical expenses to be paid at 100%.

Direct Plan:

Self Only:

In-network: Your annual out-of-pocket maximum is $6,000.

Out-of-network: Your annual out-of-pocket maximum is $7,000.

Self Plus One:

In-network: Your annual out-of-pocket maximum is $12,000.

Out-of-network: Your annual out-of-pocket maximum is $14,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is $12,000.

Out-of-network: Your annual out-of-pocket maximum is $14,000.

Once an individual meets the Self Only out-of-pocket maximum under the Self Plus One or Self and Family enrollment, the Plan will begin to cover eligible medical expenses at 100%. The remaining balance of the Self Plus One or Self and Family out-of-pocket maximum can be satisfied by one or more family members. However, certain expenses under both options do not count towards your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum. Refer to Section 4. In-network and Out-of-network out-of-pocket maximums do not cross apply and will need to be met separately in order for eligible medical expenses to be paid at 100%.

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 cancer, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan. See Section 5(b).
- 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 Section 5(b).
- 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 Section 5(b).

Coinsurance

See Section 4.

Copayment

See Section 4.

Cost-sharing

See Section 4.

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	See Section 4.
Detoxification	The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.
Emergency care	An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.
Experimental or investigational services	Services or supplies that are, as determined by us, experimental. A drug, device, procedure or treatment will be determined to be experimental if: • There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or • Required FDA approval has not been granted for marketing; or • A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or • The written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or • It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or • It is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or • It is provided or performed in special settings for research purposes.

Note: When a medical necessity determination is made utilizing the Aetna Clinical Policy Bulletins (CPBs), you may obtain a copy of the CPB through the Internet at: www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html.

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

Infertility Infertility is a disease defined as when a person is unable to conceive or produce conception after one year of egg-sperm contact when the individual attempting conception is under 35 years of age, or after six months of egg-sperm contact when the individual attempting conception is 35 years of age or older. Egg-sperm contact can be achieved by regular sexual intercourse or artificial insemination (intrauterine, intracervical, or intravaginal) as stated in our medical clinical policy bulletin (see Section 10. for definition of Medical Necessity for additional details on Aetna's Clinical Policy). This definition applies to all individuals regardless of sexual orientation or the presence/availability of a reproductive partner. Infertility may also be established by the demonstration of a disease or condition of the reproductive tract such that egg-sperm contact would be ineffective.

Medical foods The term medical food, as defined in Section 5(b) of the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

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.

Note: When a medical necessity determination is made utilizing the Aetna Clinical Policy Bulletins (CBPs), you may obtain a copy of the CPB through the Internet at: www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html.

Plan allowance

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

- Network Providers - we negotiate rates with doctors, dentists and other health care providers to help save you money. We refer to these providers as "Network Providers". These negotiated rates are our Plan allowance for network providers. We calculate a member's coinsurance using these negotiated rates. The member is not responsible for amounts that are billed by network providers that are greater than our Plan allowance.
- Non-Network Providers - Providers that do not participate in our networks are considered non-network providers. Because they are out of our network, we pay for out-of-network services based on an out-of-network Plan allowance. Here is how we figure out the Plan allowance/recognized charge.

Service or Supply: Professional services and other services or supplies not mentioned below
Plan Allowance/Recognized Charge: 105% of the Medicare allowable rate

Service or Supply: Services of hospitals and other facilities
Plan Allowance/Recognized Charge: 140% of the Medicare allowable rate

Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.

The amount of an out-of-network provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The recognized charge depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the recognized charge for specific services or supplies:

Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.Special terms used

- Involuntary services are services or supplies that are one of the following:
  - Performed at a network facility by an out-of-network provider, unless that out-of-network provider is an assistant surgeon for your surgery
  - Not available from a network provider
  - Emergency services

  We will calculate your cost share for involuntary services in the same way as we would if you received the services from a network provider.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees. We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
  - The method CMS uses to set Medicare rates
  - What other providers charge or accept as payment
  - How much work it takes to perform a service
  - Other things as needed to decide what rate is reasonable for a particular service or supply
- We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME).
- Our rate may also exclude other payments that CMS may make directly to hospitals or other providers. It also may exclude any backdated adjustments made by CMS.
- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies.
- For DME, our rate is 75% of the rates CMS establishes for those services or supplies.
- For medications payable/covered as medical benefits rather than prescription drug benefits, our rate is 100% of the rates CMS establishes for those medications.

Our reimbursement policies

We reserve the right to apply our reimbursement policies to all out-of-network services including involuntary services. Our reimbursement policies may affect the recognized charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of or related to the primary service provided
- The educational level, licensure or length of training of the provider

Our reimbursement policies are based on our review of:

- The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of physicians and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

We use the Plan allowance/Recognized charge when calculating a member's coinsurance amount. The member would be responsible for any amounts billed by the non-network provider that are above this Plan allowance/recognized charge, plus their coinsurance amount.

Note: See Section 4 of this brochure and www.aetnafeds.com for examples of member cost sharing for procedures in and out-of-network.

You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.

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

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

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

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

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

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

Reimbursement A carrier's pursuit of a recovery 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.

Rollover Any unused, remaining balance in your HDHP HSA/HRA or Medical Fund under your Aetna Direct plan at the end of the calendar year may be rolled over to subsequent years.

Subrogation A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a 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.

Surprise bill An unexpected bill you receive for

- Emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- Non-emergency services furnished by certain nonparticipating providers with respect to patient visits to participating health care facilities, or for
- Air ambulance services furnished by certain nonparticipating providers of air ambulance services.

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 determine whether or not 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 Member Services Department at 888-238-6240. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
Us/We	Us and we refer to Aetna Life Insurance Company.
You	You refers to the enrollee and each covered family member.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	Your calendar year deductible is $1,800 for Self only, $3,600 for Self Plus One or $3,600 for Self and Family enrollment for In-Network services OR $2,600 for Self only, $5,200 for Self Plus One or $5,200 for Self and Family enrollment for Out-of-Network services. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
Health Savings Account (HSA)	An HSA is a special, tax-advantaged account where money goes in tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for qualified medical services.
Health Reimbursement Arrangement (HRA)	An HRA combines a Fund with a deductible-based medical plan with coinsurance limits. The HRA Fund pays first. Once you exhaust your HRA Fund, Traditional medical coverage begins after you satisfy your deductible. Your HRA Fund counts toward your deductible.
High Deductible Health Plan (HDHP)	An HDHP is a plan with a deductible of at least $1,750 for individuals and $3,400 for families for 2026, adjusted each year for cost of living.
Maximum HSA Contribution	For 2026, the annual statutory maximum contribution is $4,400 for Self Only enrollment, $8,750 for Self Plus One enrollment and $8,750 for Self and Family enrollment.
Over age 55 additional HSA Contribution	For 2026, individuals age 55 or older may make an additional contribution of $1,000.
Premium Contribution to HSA/HRA	The amount of money we contribute to your HSA on a monthly basis. In 2026, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $66.67 per month for Self Only, $133.34 for Self Plus One and $133.34 per month for Self and Family. If you have the HRA, and are a current member or enrolled during Open Season, we contribute $800 for Self only, $1,600 for Self Plus One or $1,600 for Self and Family enrollments at the beginning of the year. If you enroll after January 1, 2026, the amount contributed will be on a prorated basis.

Consumer Driven Health Plan (CDHP) Definitions

Calendar year deductible	Your calendar year deductible is $1,600 for Self only, $3,200 for Self Plus One or $3,200 for Self and Family enrollment for In-Network services OR $1,600 for Self only, $3,200 for Self Plus One or $3,200 for Self and Family enrollment for Out-of-Network service. (Note: We will waive your deductible if you are enrolled in Medicare Part A and B and Medicare is primary). In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
Consumer Driven Health Plan	A network provider plan under the FEHB that offers you greater control over choices of your health care expenditures.
Medical Fund (Consumer Driven Health Plan)	Your Medical Fund is an established benefit amount which is available for you to use to pay for covered hospital, medical and pharmacy expenses. All of your claims will initially be deducted from your Medical Fund. Once you have exhausted your Medical Fund, and have satisfied your deductible, Traditional medical coverage begins. The Medical Fund is not a cash account and has no cash value. It does not duplicate other coverage provided by this brochure. It will be terminated if you are no longer covered by this Plan. Only eligible expenses incurred while covered under the Plan will be eligible for reimbursement subject to timely filing requirements. Unused Medical Funds are forfeited.

Index

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

Notes

Notes

Notes

Notes

Summary of Benefits for the HDHP of the Aetna HealthFund Plan - 2026

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www. aetnafeds.com.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- In 2026, for each month you are eligible for the Health Savings Account (HSA), Aetna will deposit $66.67 per month for Self Only enrollment, $133.34 for Self Plus One enrollment or $133.34 per month for Self and Family enrollment to your HSA. For the HSA, you may use your HSA or pay out of pocket to satisfy your calendar year deductible: In-network: $1,800 for Self Only enrollment, $3,600 Self Plus One enrollment and $3,600 for Self and Family enrollment or Out-of-Network $2,600 for Self Only, $5,200 for Self Plus One and $5,200 for Self and Family. Once your calendar year deductible is satisfied, Traditional medical coverage begins. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
- For the Health Reimbursement Arrangement (HRA), your health charges are applied first to your HRA Fund of $800 for Self Only, $1,600 for Self Plus One and $1,600 for Self and Family. Once your HRA is exhausted, and applied toward reducing your calendar year deductible, you must pay out-of-pocket to satisfy the remainder of your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

HDHP Benefits	You Pay	Page
In-network medical and dental preventive care	Nothing at a network provider	52-56
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	58
• In-network Teladoc Health provider consult	15% per consult	58
Services provided by a hospital: • Inpatient	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	82
• Outpatient	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	82
Emergency benefits:	In-network: 15% of our Plan allowance Out-of-network: 15% of our Plan allowance and any difference between our allowance and the billed amount.	86
Mental health and substance use disorder treatment:	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	88

HDHP Benefits	You Pay	Page
Prescription drugs: After your deductible has been satisfied, your copayment will apply. • Retail pharmacy	In-network: For up to a 30-day supply; $10 per Preferred Generic (PG) formulary drug; 50% up to $200 maximum per Preferred Brand (PB) name formulary drug; 50% up to $300 maximum per covered Non-Preferred (NP) (generic or brand name) drug. Out-of-network (retail pharmacy only): 40% plus the difference between our Plan allowance and the billed amount.	95
Prescription drugs: After your deductible has been satisfied, your copayment will apply. • Specialty Medications: For up to a 30-day supply per prescription unit or refill	Preferred Specialty (PSP): 50% up to $350 maximum Non-preferred Specialty (NPSP): 50% up to $700 maximum	97
Prescription drugs: After your deductible has been satisfied, your copayment will apply. • Mail order (available in-network only)	For a 31-day up to a 90-day supply: See Section 5(f).	95
Dental care:	No benefit other than in-network dental preventive care.	100
Vision care: In-network (only) preventive care benefits. $100 reimbursement for eyeglasses or contact lenses every 24 months.	Nothing	67
Special features: Flexible benefits option, Informed Health Line, and Services for the deaf and hearing-impaired	Contact Plan	164
Protection against catastrophic costs (out-of-pocket maximum)**:**	In-network: Nothing after $6,900/Self Only enrollment, $13,800/Self Plus One enrollment or $13,800/Self and Family enrollment per year. Out-of-network: Nothing after $9,000/Self Only enrollment, $18,000/Self Plus One enrollment or $18,000/Self and Family enrollment per year. Some costs do not count toward this protection. Your deductible counts toward your out-of-pocket maximum.	34

Summary of Benefits for the Aetna Direct Health Plan - 2026

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www. aetnafeds.com.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- For the Aetna Direct Health Plan, your health charges are applied to your Medical Fund ($900 for Self Only enrollment, $1,800 Self Plus One enrollment and $1,800 for Self and Family enrollment) plus rollover amounts. Once your Medical Fund has been exhausted, you must satisfy your calendar year deductible, $1,600 for Self Only enrollment, $3,200 for Self Plus One enrollment and $3,200 for Self and Family enrollment for in-network or $1,600 for Self Only enrollment, $3,200 for Self Plus One enrollment and $3,200 for Self and Family enrollment for out-of-network. You pay any difference between our allowance and the billed amount if you use a non-network physician or other health care professional. Once your calendar year deductible is satisfied, Traditional medical coverage begins. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.

***Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible and coinsurance for most medical services. See Section 5 for details.**

Aetna Direct Benefits	You Pay		
(Note: If you are enrolled in Medicare Part A and B and Medicare is primary, we will waive the deductible)			
Benefits	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***	**Page**
In-network medical preventive care	Nothing at a network provider	Nothing at a network provider	105-108
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount	113
• In-network Teladoc Health provider consult	In-network: 20% per consult	In-network: 0% per consult.	114
Services provided by a hospital: • Inpatient	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount	143
• Outpatient	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount	144

Benefits - continued on next page

Aetna Direct Benefits	You Pay		
Benefits (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***	**Page**
Emergency benefits:	In-network: 20% of our Plan allowance Out-of-network: 20% of our Plan allowance and any difference between our allowance and the billed amount	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount	148
Mental health and substance use disorder treatment:	In-network: 20% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount	In-network: 0% of our Plan allowance Out-of-network: 0% of our Plan allowance and any difference between our allowance and the billed amount	151
Prescription drugs:	After your deductible has been satisfied, your copayment/ coinsurance will apply.	Note: The annual deductible will be waived for pharmacy benefits, but cost sharing will still apply if Medicare Part A and B are primary and you will be automatically enrolled in the Medicare Part D Prescription Drug Plan - EGWP PDP Aetna Medicare RX® offered by SilverScript®. If you do not wish to enroll in the EGWP PDP, you may "opt-out" of the enrollment. See Section 9 for opt out information.	157
• Retail pharmacy	In network: For up to a 30-day supply per prescription or refill: $6 per Preferred Generic (PG) formulary drug; 30% per Preferred Brand (PB) name formulary drug up to a $600 maximum; and 50% per covered Non-Preferred (NP) (generic or brand name) drug up to a $600 maximum.	In network: For up to a 30-day supply per prescription or refill: • Tier 1 Preferred Generic: $0 per drug at preferred/standard pharmacy; • Tier 2 Generic: $1 per drug at preferred pharmacy; $2 per drug at standard pharmacy; • Tier 3 Preferred Brand: $45 per drug at preferred/standard pharmacy; • Tier 4 Non-Preferred Brand: $75 per drug at preferred/standard pharmacy;	157
• **Specialty Medications:** For up to a 30-day supply per prescription unit or refill	Preferred Specialty (PSP): 50% up to $600 maximum Non-preferred Specialty (NPSP): 50% up to $1,200 maximum	Tier 5 Specialty (Includes high-cost/unique generic and brand drugs): 25%, but not more than $250 per drug at preferred/ standard pharmacy;	159

Benefits - continued on next page

Aetna Direct Benefits	You Pay		
Benefits (cont.)	**Aetna Direct**	**Aetna Direct with Medicare A & B primary***	**Page**
• Mail order (available in-network only)	Mail Order Pharmacy or CVS Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $2 per Preferred Generic (PG) formulary drug; and 30% up to $100 maximum per Preferred Brand (PB) name formulary drug; and 50% up to $200 maximum per covered Non-Preferred (NP) (generic or brand name) drug.	Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: Tier 1 Preferred Generic: $0 per drug at preferred/standard pharmacy; Tier 2 Generic: $2 per drug at preferred pharmacy; $4 per drug at standard pharmacy; Tier 3 Preferred Brand: $75 per drug at preferred/standard pharmacy; Tier 4 Non-Preferred Brand: $125 per drug at preferred/standard pharmacy;	157
Vision care: In-network (only) preventive care benefits.	Nothing	Nothing	125
Special features: Flexible benefits option, Informed Health Line, and Services for the deaf and hearing-impaired	Contact Plan	Contact Plan	164
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after $6,000/ Self Only enrollment, $12,000/Self Plus One enrollment or $12,000/ Self and Family enrollment per year. Out-of-network: Nothing after $7,000/Self Only enrollment, $14,000/Self Plus One enrollment or $14,000/Self and Family enrollment per year.	In-network: Nothing after $6,000/ Self Only enrollment, $12,000/Self Plus One enrollment or $12,000/ Self and Family enrollment per year. Out-of-network: Nothing after $7,000/Self Only enrollment, $14,000/Self Plus One enrollment or $14,000/Self and Family enrollment per year.	34

2026 Rate Information for the Aetna HealthFund HDHP Plan and Aetna Direct Plan

To compare your FEHB health plan options please go to www. opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to www. opm.gov/FEHBpremiums or

www. opm.gov/Tribalpremium.

Premiums for Tribal employees are shown under the Monthly Premium Rate column. The amount shown under employee pay 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	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
HDHP Option Self Only	224	$324.76	$154.76	$703.65	$335.31
HDHP Option Self Plus One	226	$711.17	$325.85	$1,540.87	$706.01
HDHP Option Self and Family	225	$778.03	$279.69	$1,685.73	$606.00
CDHP Option Self Only	N61	$247.19	$82.39	$535.57	$178.52
CDHP Option Self Plus One	N63	$542.09	$180.70	$1,174.54	$391.51
CDHP Option Self and Family	N62	$623.37	$207.79	$1,350.64	$450.21