Aetna Advantage

www.aetnafeds.com
Customer service 888-238-6240

aetna™ **2020**

An Individual Practice Plan with an Aetna Advantage Option

Serving: In all 50 states and the District of Columbia

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 9 for details. This Plan is accredited. See page 14.

IMPORTANT
- Rates: Back Cover
- Changes for 2020: Page 22
- Summary of Benefits: Page 108

Underwritten and administered by: Aetna Life Insurance Company

Enrollment in this Plan is limited: You must live or work in our geographic service area to enroll. See pages 18-21 for requirements.

Enrollment codes for this Plan:

Z24 Aetna Advantage Plan - Self Only
Z26 Aetna Advantage Plan - Self Plus One
Z25 Aetna Advantage Plan - Self and Family

Special Notice: The Aetna Advantage Plan is a new option for the Federal Employees Health Benefits Program for 2020.

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Aetna About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits you can receive of Aetna Life Insurance Company under our contract (CS 2900) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 888-238-6240 or through our website: www.aetnafeds.com. The address for the Aetna* administrative office is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self 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, 2020, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefits are effective January 1, 2020, and changes are summarized on page 22. Rates are shown at the end of this brochure.

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

Plain Language

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

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services 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 he/she was 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 dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining 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

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

If a carrier is a covered entity, its members may file a 1557 complaint with HHS Office of Civil Rights, OPM, or FEHB Program carriers. For purposes of filing a complaint with OPM, covered carriers should use the following:

You can also file a civil rights complaint with the Office of Personnel Management by mail at:

Office of Personnel Management

Healthcare and Insurance

Federal Employee Insurance Operations

Attention: Assistant Director, FEIO

1900 E Street NW, Suite 3400-S

Washington, DC 20415-3610

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 medications 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.
   - Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. **Get the results of any test or procedure.**

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

4. **Talk to your doctor about which hospital or clinic is best for your health needs.**
   - Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital 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.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medication.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you 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, and give you brochures for other plans and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

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

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

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

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

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

If you or one of your family members is enrolled in one FEHB plan, 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 a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse or one other eligible family member as described in the chart below.

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

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the 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, 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. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2020 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2019 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

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

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

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

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

- **Converting to individual coverage**

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

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

Our Aetna Advantage Plan is a comprehensive medical plan. You can see participating or nonparticipating providers without a referral.

Preventive care services for your Aetna Advantage Plan

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

Annual deductible for your Aetna Advantage Plan

The annual deductible of $2,000 for Self Only, $4,000 for Self Plus One, or $4,000 for Self and Family in-network and $5,000 for Self Only, $10,000 for Self Plus One, or $10,000 for Self and Family out-of-network, must be met before Plan benefits are paid. 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. In-network and Out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.

Catastrophic protection for your Aetna Advantage Plan

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles, coinsurance and copayments cannot exceed $7,500 for Self Only enrollment, $15,000 for Self Plus One enrollment, or $15,000 for Self and Family enrollment for in-network services or $10,000 for Self Only enrollment, $20,000 for Self Plus One enrollment, or $20,000 for Self and Family enrollment for 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 page 36).

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). The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

Network Providers

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

Non-Network Providers

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

Your rights 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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

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 550, Blue Bell, PA 19422-0550. You may also visit our website at www.aetnafeds.com.

By law, you have the right to access your 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, "You need prior plan approval for certain services."

Patient Management

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

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

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

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

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

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

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

Member Services

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

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

Privacy Notice

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 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, which took effect October 9, 2018. 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

To get a copy of this notice, just visit our member website. 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 550, Blue Bell, PA 19422-0550. You may also contact us by fax at 215-775-5246 or visit our website at www.aetnafeds.com.

Service Area

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

Alabama, Most of Alabama – 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, Tyler, Tucker, 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 2020

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.

Aetna Advantage Option

This Plan option is new to the FEHB Program. We are being offered for the first time during the 2020 Open Season.

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.
• **Network providers**	Network providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Network providers according to national standards. We list Network providers in the provider directory, which we update periodically. The most current information on our Network providers is also on our website at www.aetnafeds.com under our online provider directory.
• **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**: If you have a chronic or disabling condition and lose access to your network specialist because we: • Terminate our contract with your specialist for other than cause; or • Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Program plan; or • Reduce our service area and you enroll in another FEHB plan, you may be able to continue seeing your specialist and receive any in-network benefits for up to 90 days after you receive notice of the change. Contact us, or, if we drop out of the Program, contact your new plan. If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and any in-network benefits continue until the end of your postpartum care, even if it is beyond the 90 days.
• **Hospital care**	Your Network primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 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)
- Autologous chondrocyte implantation
- 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
- Gender reassignment surgery
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- In-network infertility services
- Lower limb prosthetics, such as: Microprocessor controlled lower limb prosthetics
- Nonparticipating freestanding ambulatory surgical facility services, when referred by a participating provider
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)
- Osseointegrated implant
- Osteochondral allograft/knee
- Private duty nursing (see Home Health services)
- 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
- Spinal procedures, such as:
  - Artificial intervertebral disc surgery (cervical spine)
  - Cervical, lumbar and thoracic laminectomy/laminotomy procedures
  - Laminectomy with rhizotomy
  - Spinal fusion surgery
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices
- Video Electroencephalographic (EEG)
- Whole exome 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, blood clotting factors 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®, Outpatient physical therapy (PT) and occupational therapy (OT) precertification, Pain management, Polysomnography (attended sleep studies), Radiation oncology, Radiology imaging (such as CT scans, MRIs, MRAs, nuclear stress tests), Sleep Studies, Transthoracic Echocardiogram*

*For complete list refer to:

https://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.

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 from the receipt of this notice to provide the required information. We will make our decision on the claim within 48 hours (1) of the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 888-238-6240. You may also call OPM's FEHB3 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 telephone us within one (1) business day following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than a total of three (3) days 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 confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

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

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

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

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

Circumstances beyond our control

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

If you disagree with our pre-service claim decision

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

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

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

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

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

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

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

The Federal Flexible Spending Account Program – *FSAFEDS*

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

Section 4. Your Cost for Covered Services

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

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Copayments	A copay is the fixed amount of money you pay when you receive certain services. Example: You pay a copayment of $10 to the pharmacy when you receive generic drugs on our formulary list.
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. **Aetna Advantage Plan** You must satisfy your deductible before your Traditional medical coverage begins. Note: Preventive services, are not subject to the annual deductible. Your annual deductible is $2,000 for a Self Only enrollment, $4,000 for a Self Plus One enrollment and $4,000 for Self and Family enrollment in-network and $5,000 for a Self Only enrollment, $10,000 for a Self Plus One, and $10,000 for a 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 or 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 change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: You pay 30% of our Plan allowance for in-network durable medical equipment.
Differences between our Plan allowance and the bill	Network Providers agree to accept our Plan allowance so if you use a network provider, you never have to worry about paying the difference between our Plan allowance and the billed amount for covered services. Non-Network Providers: If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount. By using health care providers in Aetna's network, you can take advantage of the significant discounts we have negotiated to help lower your out-of-pocket costs for medically necessary care. This can help you get the care you need at a lower price. The example below is based on the following Aetna health benefits and insurance plan features and assumes you've already met your deductible: What your plan pays (plan coinsurance): 70% in-network/50% out-of-network What you pay (coinsurance): 30% in-network/50% out-of-network Your out-of-pocket maximum: $7,500/$15,000 in-network; $10,000/$20,000 out-of-network***

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

		In-network	Out-of-network
Hospital bill	Amount billed	$25,000	$25,000
Amount Aetna uses to calculate payment	in-network rate*	$8,750	
Amount Aetna uses to calculate payment	Recognized amount** out-of-network		$8,750
What your Aetna plan will pay	Negotiated / recognized amount	$8,750	$8,750
What your Aetna plan will pay	Percent your plan pays	70%	50%
What your Aetna plan will pay	Aetna's negotiated rate/recognized amount covered under plan	$6,125	$4,375
What you owe	Your coinsurance responsibility (In-network 30%, Out-of-network 50%)	$2,625	$4,375
What you owe	Amount that can be balance billed to you	$0	$16,250
What you owe	Your total responsibility	$2,625	$20,625

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

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

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

Your catastrophic protection out-of-pocket maximum

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

Aetna Advantage Plan

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

Note: For the Aetna Advantage 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 $7,500.

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

Self Plus One:

In-network: Your annual out-of-pocket maximum is $15,000.

Out-of-network: Your annual out-of-pocket maximum is $20,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is $15,000.

Out-of-network: Your annual out-of-pocket maximum is $20,000.

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

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

Carryover

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

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

When Government facilities bill us

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

Aetna Advantage Plan Benefits

See pages 108-109 for a benefits summary.

Section 5. Aetna Advantage Plan Benefits Overview

Section 5, which describes the Aetna Advantage 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 these benefits, contact us at 888-238-6240 or on our website at www.aetnafeds.com.

Aetna Advantage option offers unique features:

- Extensive provider network.

- No requirement to choose a single doctor as your primary physician.

- No referral needed to see a specialist. However, you might need prior plan approval for certain services.

- Freedom to choose any doctor with extra savings when you see a preferred provider.

- Teladoc®, who has over 700 U.S. board-certified, state-licensed health care professionals. This virtual option provides added convenience for members, who can reach Teladoc online, by phone or mobile app

- Low bi-weekly and monthly premiums!

- **Lower out-of-pocket costs and option to choose a Medicare Advantage Plan if Medicare Parts A and B are primary. (see next page)**

Aetna Advantage Plan (if Original Medicare is not primary)

Brochure Section	Medical Benefit	Member Pays (In-network)
Section 5	Deductible	$2,000 (Self Only)/$4,000(Self Plus One or Self and Family)
Section 5	Coinsurance (medical)	30% of the Plan allowance
Section 5	Catastrophic Maximum	$7,500 (Self Only)/$15,000 (Self Plus One or Self and Family)
5(a)	Professional visit (PCP/Specialist)	30% of Plan allowance
5(a)	Telehealth	$40 until the deductible is met, 30% of the $40 consult fee thereafter.
5(a)	Preventive care (adult/child)	$0
5(b)	Surgical care	30% of Plan allowance
5(c)	Inpatient hospital	30% of Plan allowance
5(c)	Outpatient	30% of Plan allowance
5(d)	Emergency Room/Urgent Care	30% of Plan allowance
5(f)	Pharmacy Tier 1 (30-day supply)	$10
5(f)	Pharmacy Tier 2 (30-day supply)	45%

Aetna Medicare Advantage Plan (Medicare parts A and B are primary)

(available for Medicare primary members who have opted into Aetna Medicare Advantage by calling 866-241-0262 or going to www.aetnaretireehealth.com/fehbp)

Annual Cost-Share	Medical Benefit	Member Pays
Section 9	Deductible	$0
Section 9	Coinsurance (medical)	0% of the Plan allowance
Section 9	Catastrophic Maximum	$6,350 (per person)
Section 9	Professional visit (PCP/ Specialist)	0% of Plan allowance
Section 9	Preventive care (adult/ child)	$0
Section 9	Surgical care	0% of Plan allowance
Section 9	Inpatient hospital	0% of Plan allowance
Section 9	Outpatient	0% of Plan allowance
Section 9	Emergency Room/Urgent Care	0% of Plan allowance
Section 9	Pharmacy Tier 1 (30-day supply)	$2
Section 9	Pharmacy Tier 2 (30-day supply)	$10
Section 9	Pharmacy Tier 3 (30-day supply)	$40
Section 9	Pharmacy Tier 4 (30-day supply)	$75
Section 9	Pharmacy Tier 5 (30-day supply)	25% up to $350

*** Note: If you enroll in Aetna Advantage and are covered by Medicare Parts A and B and it is primary, we offer an Aetna Medicare Advantage plan to our FEHB members. This plan enhances your FEHB coverage by lowering/ eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage plan is subject to Medicare rules. (See page 94 for additional details.)**

By choosing this plan, retired enrollees age 65 and over with Medicare as primary coverage, agree that you have or will have Medicare Parts A and B by your effective date. You agree that you will be enrolled in our Aetna Medicare Advantage Plan. We may need more information to enroll you in this plan prior to your effective date. If this is not completed, your benefits will be significantly impacted, i.e. $2,000 deductible not waived and you will pay 30% coinsurance on most services.

Member Tools, Resources and Additional programs:

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.

Additional programs (available for Medicare primary members who have opted into Aetna Medicare Advantage by calling 866-241-0262 or going to www.aetnaretireehealth.com/fehbp)

SilverSneakers®

An overall wellness program that may help members improve their health and live the life they want. The program gives members access to exercise equipment, classes, and fun social activities at thousands of locations nationwide.

Hearing aid reimbursement

Reimbursement is $2,000/every 36 months

Resources For Living

Aetna signature program which helps you find the resources you need in your daily life. With just one call, a life consultant can help you find local resources to make life easier and treat your entire health, including your social and mental well-being.

Non-emergency transportation program

A program that ensures you make it to and from your doctors or hospital appointments without always having to rely on family or friends.

Meal Benefit program

Aetna offers a meal benefit through our relationship with GA Foods. The program offers 14 home delivered meals, after an inpatient hospital stay.

Section 5. Medical Preventive Care

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

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

*** Note: If you enroll in Aetna Advantage and are covered by Medicare Part A and B and it is primary, we offer an Aetna Medicare Advantage plan to our FEHB members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage Plan is subject to Medicare rules. (See page 94 for additional details.)**

Benefit Description	You pay
Medical Preventive Care, adult	
Screenings, such as: • Blood tests • Routine urine tests • Total blood cholesterol • Depression • Diabetes • High blood pressure • HIV • Fasting lipid profile • Routine Prostate Specific Antigen (PSA) test — one (1) annually for men age 40 and older • Colorectal cancer screening, including: - Fecal occult blood test yearly starting at age 45 - Sigmoidoscopy screening - every five (5) years starting at age 45 - Colonoscopy screening - every ten (10) years starting at age 45 - Stool DNA (FIT-DNA, Cologuard) - every three (3) years • Lung cancer screening - one (1) screening annually from age 55 and over Note: Physician consultation for colorectal screening visits prior to the procedure are not considered preventive.	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 50% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5).

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay
Medical Preventive Care, adult (cont.)	
• Abdominal aortic aneurysm screening – Ultrasonography, one (1) screening for men age 65 and older • Dietary and nutritional counseling for obesity - 26 visits annually • Routine annual digital rectal exam (DRE) for men age 40 and older Note: Some tests provided during a routine physical may not be considered preventive.	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 50% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5).
Well woman care based on current recommendations such as: • Routine well woman exam (one (1) visit per calendar year) • Cervical cancer screening (Pap smear) • Human papillomavirus (HPV) testing • Chlamydia/gonorrhea screening • Gonorrhea prophylactic medication to protect newborns • Osteoporosis screening • Breast cancer screening • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Generic contraceptive methods and counseling. • Screening and counseling for interpersonal and domestic violence • Perinatal depression: counseling and interventions • Screening for diabetes mellitus after pregnancy • Screening for urinary incontinence	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 50% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5).
• Routine mammogram - covered for women - 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 50% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5).

• Routine physicals:
  - One (1) exam every calendar year
• Routine exam:
  - The following exams limited to:
    • One (1) routine eye exam every 12 months
• Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule
  - Tetanus, Diphtheria and Pertussis (Tdap) vaccine as a single dose for those 19 years of age and above
  - Tetanus-Diphtheria (Td) booster every ten (10) years
  - Influenza vaccine, annually
  - Varicella (chicken pox) vaccine for age 19 to 49 years without evidence of immunity to varicella
	In-network: Nothing at a network provider.
	
	Out-of-network: All charges until you satisfy your deductible, then 50% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5).

Medical Preventive Care, adult - continued on next page

Benefit Description	You pay
Medical Preventive Care, adult (cont.)	
- Pneumococcal vaccine, 23-valent and if not previously received 13-valent Pneumococcal vaccines, age 65 and over - Human papillomavirus (HPV) vaccine for age 9 through age 27 - Herpes Zoster (Shingles) vaccine for age 50 and older 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.	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 50% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5).
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicetaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. HHS: www.healthcare.gov/preventive-care-benefits/. CDC: www.cdc.gov/vaccines/schedules/index.html. Women's preventive services: www.healthcare.gov/preventive-care-women/. For additional information: healthfinder.gov/myhealthfinder/default.aspx	
Not covered: • *Physical exams, immunizations, and boosters 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*
Medical Preventive Care, children	
Well-child visits, examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. • We follow the CDC recommendations for preventive care and immunizations. Go to www.aetnafeds.com for the list of preventive care and immunizations. • 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	In-network: Nothing at a network provider Out-of-network: All charges until you satisfy your deductible, then 50% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5).

Medical Preventive Care, children - continued on next page

Benefit Description	You pay
Medical Preventive Care, children (cont.)	
• Screening examination of premature infants for Retinopathy of Prematurity-A retinal eye screening exam performed by an ophthalmologist for infants with low birth weight (<1500g) or gestational age of 32 weeks or less and infants weighing between 1500 and 2000g or gestational age of more than 32 weeks with an unstable clinical course. • Hearing loss screening of newborns provided by a participating hospital before discharge • One (1) routine eye exam every 12 months through age 17 to determine the need for vision correction • One (1) routine hearing exam every 24 months through age 17 to determine the need for hearing correction • Dietary and nutritional counseling for obesity - unlimited visits Examinations, limited to: • Examinations for amblyopia and strabismus - limited to one (1) screening examination (ages 3 through 5) • Examinations done on the day of immunizations (ages 3 up to age 22) Note: Some tests provided during a routine physical may not be considered preventive. Contact Member Services at 888-238-6240 for information on whether a specific test is considered routine.	In-network: Nothing at a network provider Out-of-network: All charges until you satisfy your deductible, then 50% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5).
Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicetaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. HHS: www.healthcare.gov/preventive-care-benefits/. CDC: www.cdc.gov/vaccines/schedules/index.html. For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to: brightfutures.aap.org/Pages/default/aspx.	
Not covered: • *Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.*	*All charges*

Section 5. Traditional Medical Coverage Subject to the Deductible

Important things you should keep in mind about these benefits:

- Traditional medical coverage does not begin to pay until you have satisfied your deductible.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network medical preventive care is covered at 100% (see page 38) and is not subject to your calendar year deductible.
- The deductible is: In-network - $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment and Self and Family enrollment or Out-of-Network - $5,000 per Self Only, $10,000 for Self Plus One enrollment and Self and Family enrollment. Once an individual meets the Self Only 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 or Self and Family deductible can be satisfied by one or more family members. You must satisfy the deductible before your Traditional medical coverage may begin. 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 $7,500 in-network and $10,000 out-of-network per Self Only enrollment, $15,000 in-network and $20,000 out-of-network per Self Plus One enrollment or $15,000 in-network and $20,000 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.

*** Note: If you enroll in Aetna Advantage and are covered by Medicare Part A and B and it is primary, we offer an Aetna Medicare Advantage plan to our FEHB members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage plan is subject to Medicare rules. (See page 94 for additional details.)**

Benefit Description	You pay
Deductible before Traditional medical coverage begins	
You must satisfy your deductible before your Traditional medical coverage begins. 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: $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment and $4,000 for Self and Family enrollment or Out-of-Network: $5,000 per Self Only enrollment, $10,000 for Self Plus One enrollment or $10,000 per Self and Family enrollment.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment and Self and Family enrollment or Out-of-Network - $5,000 per Self Only, $10,000 for Self Plus One enrollment and Self and Family enrollment. Once an individual meets the Self Only 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 or Self and Family deductible can be satisfied by one or more family members. You must satisfy the deductible before your Traditional medical coverage may begin. 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.

*** Note: If you enroll in Aetna Advantage and are covered by Medicare Part A and B and it is primary, we offer an Aetna Medicare Advantage plan to our FEHB members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage plan is subject to Medicare rules. (See page 94 for additional details.)**

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office - Office medical evaluations, examinations and consultations - Second surgical or medical opinion - Initial examination of a newborn child covered under a Self Plus One or Self and Family enrollment • In an urgent care center • During a hospital stay • In a skilled nursing facility • At home	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible…
Telehealth services	
• Teladoc consult Please see www.aetnafeds.com for information on Teladoc service. Note: Members will receive a Teladoc welcome kit explaining the benefit. Note: Teladoc is not available for phone service in Idaho (video consults only). Note: For Behavioral Health telemedicine consults, please see section 5(e).	In-network: $40 until the deductible is met, 30% of the $40 consult fee thereafter. Out-of-network: No benefit. Must use Teladoc provider.
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CT Scans/MRI* • Ultrasound • Electrocardiogram and electroencephalogram (EEG) Note: See Section 5(c) for cost sharing for these services not performed in a doctor's office. *Note: CT Scans and MRIs require precertification see "Services requiring our prior approval" on pages 24-26.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
• Genetic Counseling and Evaluation for BRCA Testing • Genetic Testing for BRCA-Related Cancer* *Note: Requires precertification. See "Services requiring our prior approval" on pages 24-26.	In-network: Nothing at a network provider Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Maternity care	
• 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. 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	In-network: No cost share (no deductible) for routine prenatal care or the first postpartum care visit when services are rendered by an in-network delivering health care provider, 30% of our Plan allowance for postpartum care visits thereafter. Out-of-network: 50% 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.)	
- Inpatient admissions - Ultrasounds • Screening for gestational diabetes for pregnant women • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see below for other circumstances, such as extended stays for you or your baby. • 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. Surgical benefits, not maternity benefits, apply to circumcision. • See Hospital benefits (Section 5c) no member cost sharing (deductible and coinsurance) for in-network inpatient maternity care and Surgery benefits (Section 5b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	In-network: No cost share (no deductible) for routine prenatal care or the first postpartum care visit when services are rendered by an in-network delivering health care provider, 30% of our Plan allowance for postpartum care visits thereafter. Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Breastfeeding support, supplies and counseling for each birth	In-network: Nothing at a network provider (no deductible) Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Home births	*All charges*
Family planning	
A range of voluntary family planning services limited to: • Contraceptive counseling on an annual basis • Voluntary sterilization (See *Surgical procedures* (Section 5b) • Surgically implanted contraceptives • Generic injectable contraceptive drugs, such as Depo-Provera • Intrauterine devices (IUDs) • Diaphragms	Nothing for women (no deductible) For men: In-network: 30% of our Plan allowance Out-of-network: 50% 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.)	
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.	Nothing for women (no deductible) For men: In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing counseling*	*All charges*
Infertility services	
Infertility is a disease defined by the failure to conceive a pregnancy after 12 months or more of timed intercourse or egg-sperm contact for women under age 35 (six (6) months for women age 35 or older). • Testing for diagnosis and surgical treatment of the underlying medical cause of infertility.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Any assisted reproductive technology (ART) procedure or services related to such procedures, including but not limited to in-vitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), zygote intra-fallopian transfer (ZIFT), and intra-cytoplasmic sperm injection (ICSI) or* • *Artificial insemination (AI) and monitoring of ovulation:* *• Intravaginal insemination (IVI)* *• Intracervical insemination (ICI)* *• Intrauterine insemination (IUI) or* • *Any charges associated with care required to obtain Artificial insemination or ART services (e.g. office, hospital, ultrasounds, laboratory tests, etc); and any charges associated with obtaining sperm for any Artificial insemination or ART procedures.* • *Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services* • *Services associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g. office, hospital, ultrasounds, laboratory tests etc.)* • *Services and supplies related to the above mentioned services, including sperm processing* • *The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;* • *Reversal of sterilization surgery.*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	
• *Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal* • *Injectable fertility drugs, including but not limited to menotropins, hCG, GnRH agonists, and IVIG* • *Cost of home ovulation predictor kits or home pregnancy kits* • *Drugs related to the treatment of non-covered benefits* • *Infertility services that are not reasonably likely to result in success*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections • Allergy serum	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/ Tissue Transplants on page 57. • 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. Note: We will only cover GHT when we preauthorize the treatment. Call 888-238-6240 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and it is authorized by Aetna. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. Note: Applied Behavior Analysis (ABA) - Children with autism spectrum disorder is covered under mental health. (See section 5(e))	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies	
60 visits per person, per calendar year for physical or occupational therapy, or a combination of both for the services of each of the following: • Qualified Physical therapists • Occupational therapists Note: 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: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Long-term rehabilitative therapy*	*All charges*
Pulmonary and cardiac rehabilitation	
• 20 visits per condition per member per calendar year for pulmonary rehabilitation to treat functional pulmonary disability. • Cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or a myocardial infarction is provided for up to three (3) visits a week for a total of 18 visits.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Long-term rehabilitative therapy	*All charges*
Habilitative Services	
Habilitative services for congenital or genetic birth defects including, but not limited to, autism or an autism spectrum disorder, and cerebral palsy. Treatment is provided to enhance the ability to function. Services include occupational therapy, physical therapy and speech therapy. Note: See Occupational therapy, physical therapy and speech therapy for plan coverage and limitations.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible…
Speech therapy	
• 60 visits per person, per calendar year.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Hearing services (testing, treatment, and supplies)	
• Hearing exams for children through age 17 (*as shown in Preventive Care, children*) • One (1) hearing exam every 24 months for adults • Audiological testing and medically necessary treatments for hearing problems. Note: Discounts on hearing exams, hearing services, and hearing aids are also available. Please see the Non-FEHB Benefits section of this brochure for more information.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *All other hearing testing and services that are not shown as covered* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Treatment of eye diseases and injury	In-network: 30% of our Plan allowance Out-of-network: 50% 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: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Fitting of contact lenses* • *Vision therapy, including eye patches and eye exercises, e.g., orthoptics, pleoptics, for the treatment of conditions related to learning disabilities or developmental delays* • *Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors*	*All charges*
Foot care	
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 30% of our Plan allowance Out-of-network: 50% 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*	*All charges*

Foot care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Foot care (cont.)	
• *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open manipulation or fixation)* • *Foot orthotics* • *Podiatric shoe inserts*	*All charges*
Orthopedic and prosthetic devices	
• Orthopedic devices such as braces and corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and prosthetic devices such as artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), 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: 30% of our Plan allowance Out-of-network: 50% 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: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Orthopedic and corrective shoes not attached to a covered brace* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Podiatric shoe inserts* • *Lumbosacral supports* • *All charges over $500 for hair prosthesis*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Contact Plan at 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: 30% of our Plan allowance Out-of-network: 50% 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.)	
• Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Insulin pumps and related supplies such as needles and catheters • Certain bathroom equipment such as bathtub seats, benches and lifts Note: Some DME may require precertification by you or your physician.	In-network: 30% of our Plan allowance Out-of-network: 50% 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*	*All charges*
Home health services	
• Home health services ordered by your attending physician and provided by nurses and home health aides through a home health care agency. Home health services include skilled nursing services provided by a licensed nursing professional; services provided by a physical therapist, occupational therapist, or speech therapist; and services of a home health aide when provided in support of the skilled home health services. Home health services are limited to 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: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Intravenous (IV) Infusion Therapy and medications	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Nursing care for the convenience of the patient or the patient's family* • *Transportation* • *Custodial care, i.e., home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative and appropriate for the active treatment of a condition, illness, disease, or injury* • *Services of a social worker*	*All charges*

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Home health services (cont.)	
• *Services provided by a family member or resident in the member's home* • *Services rendered at any site other than the member's home* • *Services rendered when the member is not homebound because of illness or injury* • *Private duty nursing services*	*All charges*
Chiropractic	
No benefit	*All charges*
Educational classes and programs	
Aetna Health Connections offers disease management for 34 conditions. Included are programs for: • Asthma • Cerebrovascular disease • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure (CHF) • Coronary artery disease • Cystic Fibrosis • Depression • Diabetes • Hepatitis • Inflammatory bowel disease • Kidney failure • Low back pain • Sickle cell disease To request more information on our disease management programs, call 888-238-6240.	Nothing
Coverage is provided for: • Tobacco Cessation/E-cigarettes Programs, including individual group/ telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Note: OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	In-network: Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence. Out-of-network: Nothing up to our Plan allowance for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing up to our Plan allowance for OTC drugs and prescription drugs approved by the FDA to treat tobacco dependence.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment and Self and Family enrollment or Out-of-Network - $5,000 per Self Only, $10,000 for Self Plus One enrollment and Self and Family enrollment. Once an individual meets the Self Only 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 or Self and Family deductible can be satisfied by one or more family members. You must satisfy the deductible before your Traditional medical coverage may begin. 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 the facility (i.e., hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

*** Note: If you enroll in Aetna Advantage and are covered by Medicare Part A and B and it is primary, we offer an Aetna Medicare Advantage plan to our FEHB members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage plan is subject to Medicare rules. (See page 94 for additional details.)**

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery)	In-network: 30% of our Plan allowance Out-of-network: 50% 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.)	
• Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual has a body mass index (BMI) exceeding 40 or a BMI greater than 35 in conjunction with documented significant co-morbid conditions (such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea or refractory hypertension).** - Eligible members must be age 18 or over or have completed full growth. - Members must complete a physician-supervised nutrition and exercise program within the past two (2) years for a cumulative total of six (6) months or longer in duration, with participation in one (1) program for at least three (3) consecutive months, prior to the date of surgery documented in the medical record by an attending physician who supervised the member's participation; or member participation in an organized multidisciplinary surgical preparatory regimen of at least three months duration proximate to the time of surgery. All programs/regimens must be completed within six (6) months prior to surgery and the member must not have a net gain in weight during the program. - For members who have a history of severe psychiatric disturbance or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary. **We will consider:** • Open or laparoscopic Roux-en-Y gastric bypass; or • Open or laparoscopic biliopancreatic diversion with or without duodenal switch; or • Sleeve gastrectomy; or • Laparoscopic adjustable silicone gastric banding (Lap-Band) procedures. • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization for men (e.g.,vasectomy) • Treatment of burns • Skin grafting and tissue implants • Gender reassignment surgery* - The Plan will provide coverage for the following when the member meets Plan criteria: • Surgical removal of breasts for female-to-male patients • Surgical removal of uterus and ovaries in female-to-male and testes in male-to-female • Reconstruction of external genitalia**	In-network: 30% of our Plan allowance Out-of-network: 50% 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.)	
* Subject to medical necessity ** Note: Requires Precertification. See "Services requiring our prior approval" on pages 24-26. 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: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
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 Foot care)* • *Gender reassignment services that are not considered medically necessary*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital and developmental anomalies are cleft lip, cleft palate, webbed fingers, and webbed toes. All surgical requests must be preauthorized. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedema - breast prostheses and surgical bras and replacements (*see Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form and for which the disfigurement is not associated with functional impairment, except repair of accidental injury*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery	
Oral surgical procedures, that are medical in nature, such as: • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ (must be preauthorized); and • Excision of tumors and cysts. Note: When requesting oral and maxillofacial services, please check our online provider directory or call Member Services at 888-238-6240 for a participating oral and maxillofacial surgeon.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Dental implants* • *Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under *You need prior Plan approval for certain services* on pages 24-26. • 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: 30% of our Plan allowance Out-of-network: 50% 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)	In-network: 30% of our Plan allowance Out-of-network: 50% 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.)	
- Recurrent germ cell tumors (including testicular cancer)	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Blood or marrow stem cell transplants Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. 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 neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)* - Hemoglobinopathies - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders (i.e. Fanconi's, 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	In-network: 30% of our Plan allowance Out-of-network: 50% 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.)	
- 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 - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors *Approved clinical trial necessary for coverage.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - 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 - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia	In-network: 30% of our Plan allowance Out-of-network: 50% 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.)	
• Autologous transplants for: - Acute lymphocytic or nonlymphocytic (ie.e, myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	In-network: 30% of our Plan allowance Out-of-network: 50% 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.)	
- Multiple myeloma - Myelodysplasia/Myelodysplastic Syndromes - Multiple sclerosis - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell anemia • Autologous Transplants for: - Advanced Childhood kidney cancers - Advance Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - 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 - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	In-network: 30% of our Plan allowance Out-of-network: 50% 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.)	
• **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 an IOE hospital 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: 30% of our Plan allowance Out-of-network: 50% 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.)	
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: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials. Terminal illness means a medical prognosis of 6 months or less to live); and* • *Costs of data collection and record keeping that would not be required but for the clinical trial; and* • *Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs"); and* • *Items and services provided by the trial sponsor without charge* • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services (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: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- You must satisfy your deductible before your Traditional medical coverage begins. Your annual deductible is $2,000 for a Self Only enrollment, $4,000 for a Self Plus One enrollment and $4,000 for Self and Family enrollment in-network and $5,000 for a Self Only enrollment, $10,000 for a Self Plus One, and $10,000 for a 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 or 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.
- 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.

*** Note: If you enroll in Aetna Advantage and are covered by Medicare Part A and B and it is primary, we offer an Aetna Medicare Advantage plan to our FEHB members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage plan is subject to Medicare rules. (See page 94 for additional details.)**

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	
Room and board, such as • Private, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	In-network: 30% of our Plan allowance Out-of-network: 50% 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	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.

Inpatient hospital - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
• 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: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Whole blood and concentrated red blood cells not replaced by the member* • *Non-covered facilities, such as nursing homes, schools* • *Custodial care, rest cures, domiciliary or convalescent cares* • *Personal comfort items, such as a telephone, television, barber service, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and 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.	In-network: 30% of our Plan allowance Out-of-network: 50% 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.)	
Note: In-network preventive care services are not subject to coinsurance listed.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Whole blood and concentrated red blood cells not replaced by the member.	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 60-day limit per calendar year when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: Custodial care	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of your attending Physician, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less. Note: Inpatient hospice services require prior approval.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Ambulance	
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member.	In-network: 30% of our Plan allowance Out-of-network: 50% 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*	*All charges*

Ambulance - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Ambulance (cont.)	
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 - $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment and Self and Family enrollment or Out-of-Network - $5,000 per Self Only, $10,000 for Self Plus One enrollment and Self and Family enrollment. Once an individual meets the Self Only 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 or Self and Family deductible can be satisfied by one or more family members. You must satisfy the deductible before your Traditional medical coverage may begin. 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.

*** Note: If you enroll in Aetna Advantage and are covered by Medicare Part A and B and it is primary, we offer an Aetna Medicare Advantage plan to our FEHB members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage plan is subject to Medicare rules. (See page 94 for additional details.)**

What is a medical emergency?

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

What to do in case of emergency:

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

Benefit Description	You pay After the calendar year deductible…
Emergency	
• Emergency or urgent care at a doctor's office • Emergency or urgent care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services	In-network: 30% of our Plan allowance Out-of-network: 30% 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	
• Teladoc consult Please see www.aetnafeds.com for information on Teladoc service. Note: Members will receive a Teladoc welcome kit explaining the benefit Note: Teladoc is not available for phone service in Idaho (video consult only).	In-network: $40 until the deductible is met, 30% of the $40 consult fee thereafter. Out-of-network: No benefit. Must use Teladoc provider.
Ambulance	
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member. Note: Air ambulance may be covered. Prior approval is required.	In-network: 30% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency* • *Ambulette service* • *Air ambulance without prior approval* • *Ambulance transportation for member convenience or for reasons that are not medically necessary* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*

Section 5(e). Mental Health and Substance 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.
- The deductible is: In-network - $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment and Self and Family enrollment or Out-of-Network - $5,000 per Self Only, $10,000 for Self Plus One enrollment and Self and Family enrollment. Once an individual meets the Self Only 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 or Self and Family deductible can be satisfied by one or more family members. You must satisfy the deductible before your Traditional medical coverage may begin. 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.
- 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.

*** Note: If you enroll in Aetna Advantage and are covered by Medicare Part A and B and it is primary, we offer an Aetna Medicare Advantage plan to our FEHB members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage plan is subject to Medicare rules. (See page 94 for additional details.)**

Benefit Description	You pay After the calendar year deductible…
Professional services	
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: 30% of our Plan allowance Out-of-network: 50% 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.)	
• Substance Use Disorder (SUD) office visits to Behavioral Health practitioner • Routine psychiatric office visits to Behavioral Health practitioner • Behavioral therapy	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
• Telemedicine Behavioral Health consult	In-network: 30% of our Plan allowance Out-of-network: Not covered
Skilled behavioral health services provided in the home, but only when all of the following criteria are met: • Your physician orders them • The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home • The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications	In-network: 30% of our Plan allowance Out-of-network: 50% 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 "Services requiring our prior approval" on pages 24-26. 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: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Diagnostics	
• 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: 30% of our Plan allowance Out-of-network: 50% 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	
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: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility including other outpatient mental health treatment such as: • Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician • Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician • Outpatient detoxification • Ambulatory detoxification which is outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications • Treatment of withdrawal symptoms • Electro-convulsive therapy (ECT) • Mental health injectables • Substance abuse injectables • Transcranial magnetic stimulation (TMS)	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered	
• *Educational services for treatment of behavioral disorders* • *Services in half-way houses*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- This is a two tier closed formulary pharmacy plan, High Value Formulary. The formulary is a list of drugs that your health plan covers. With your High Value Formulary Pharmacy Plan, each drug is grouped as a generic or a brand . Each tier has a separate out-of-pocket cost.
  - Preferred generic
  - Preferred Brand
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- The deductible is: In-network - $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment and Self and Family enrollment or Out-of-Network - $5,000 per Self Only, $10,000 for Self Plus One enrollment and Self and Family enrollment. Once an individual meets the Self Only 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 or Self and Family deductible can be satisfied by one or more family members. You must satisfy the deductible before your Traditional medical coverage may begin. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/precertification for certain prescription drugs and supplies before coverage applies. Prior approval/precertifications must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Upon approval by the Plan, the prescription is covered for the current calendar year or a specified time period, whichever is less.
- **During the course of the year, we may move a brand-name drug from Tier 2 (preferred brand-name, preferred generic specialty and preferred brand-name specialty drugs) to non-covered if a generic equivalent or biosimilar becomes available or if new safety concerns arise. If your drug is moved to non-covered, you pay the full cost of the medication. Tier reassignments during the year are not considered benefit changes.**

*** Note: If you enroll in Aetna Advantage and are covered by Medicare Part A and B and it is primary, we offer an Aetna Medicare Advantage plan to our FEHB members. This Plan enhances your FEHB coverage by lowering your cost-sharing for Pharmacy tiers at no additional cost. Aetna Medicare Advantage plan is subject to Medicare rules. (See page 95 for each Rx tier cost share.)**

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.

- **Where you can obtain them**. You may fill non-emergency prescriptions at a participating Plan retail pharmacy or by mail order for up to a 90-day supply of medication (if authorized by your physician). In no event will the copay exceed the cost of the prescription drug. 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 Specialty pharmacy. Prescriptions ordered through a Specialty pharmacy are only filled for up to a 30-day supply due to the nature of these prescriptions.** In an emergency or urgent care situation, you may fill your covered prescription at any retail pharmacy. For retail pharmacy transactions, you must present your Aetna Member ID card at the point of sale for coverage. If you obtain an emergency prescription at a pharmacy that does not participate with the plan, you will need to pay the pharmacy the full price of the prescription and submit a claim for reimbursement subject to the terms and conditions of the plan.
- **We use a formulary.** The formulary is a list of drugs that your Plan covers. Drugs are prescribed by Plan doctors and dispensed in accordance with the 2020 Pharmacy Drug (Formulary) Guide. Certain drugs require your doctor to get precertification or requires step therapy before they can be covered under the Plan. Your prescription drug plan includes drugs listed in the 2020 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. Visit our website at www.aetnafeds/pharmacy.com to review our 2020 Pharmacy Drug (Formulary) Guide or call 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. The High Value formulary is a closed formulary, which means in order for your drug to be covered, it must be on our formulary. Drugs not on the High Value formulary will not be covered. Remember, a generic equivalent will be dispensed, if available, unless your physician specifically requires a brand name and writes "Dispense as Written" (DAW) on the prescription, so discuss this with your doctor.
- **Choose generics.** The Plan requires the use of generics if a generic drug is available. If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/ coinsurance* unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained from the Plan. Generics contain the same active ingredients in the same amounts as their brand name counterparts and have been approved by the FDA. By using generic drugs, you will see cost savings, without jeopardizing clinical outcome or compromising quality. * 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.
- **These are the dispensing limitations.** Prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy for up to 30-day supply or by mail order may be dispensed for up to a 90-day supply of medication (if authorized by your physician). In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available, unless your physician specifically requires a brand name.In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filing of their medication(s) prior to departure, their pharmacist will need to contact Aetna. Coverage of additional prescriptions will only be allowed if there are refills remaining on the member's current prescription or a new prescription has been issued by their physician. The member is responsible for the applicable cost sharing for the additional prescription.

  Aetna allows coverage of a medication refill when at least 80% of the previous prescription, according to the physician's prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a prescription refill to be covered 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, Pharmacy Management, P.O. Box 52444, Phoenix, AZ 85072-2444.

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

- A generic equivalent may be dispensed if it is available, and where allowed by law.
- **Specialty drugs.** Specialty drugs are medications that treat complex, chronic diseases which includes select oral, injectable and infused medications. The first fill including all subsequent refills of these medications must be obtained through a participating specialty pharmacy.
- Certain Specialty Formulary medications identified on the Specialty Drug List next to the drug name maybe 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 share. If you obtain the prescribed medications directly from a participating specialty pharmacy, you will pay the applicable cost share 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 or contact us at 888-238-6240 for a copy. Note that the medications and categories covered are subject to change.
- **To request a printed copy of the 2020 Pharmacy Drug (Formulary) Guide, call 888-238-6240.** The information in the 2020 Pharmacy Drug (Formulary) Guide is subject to change. As brand name drugs lose their patents and new generics become available on the market, the brand name drug may be removed from the formulary. Under your benefit plan, this will result in a savings to you, as you pay a lower prescription copayment for generic formulary drugs. Please visit our website www.aetnafeds.com/pharmacy for current 2020 Pharmacy Drug (Formulary) Guide information.

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies	
We cover the following medications and supplies prescribed by 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) Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained.	**In-network:** 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 or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered preferred generic formulary drug; and 45% per covered preferred brand formulary drug. Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 per covered preferred generic formulary drug; and 45% per covered preferred brand formulary drug. **Out-of-network (retail pharmacies only):** 50% plus the difference between our Plan allowance and the billed amount

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
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 (no deductible) **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: 45% per covered preferred brand formulary drug. Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: 45% per covered preferred brand formulary 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 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 page 75, Specialty Drugs for more information or visit: www.aetnafeds.com/pharmacy.	Up to a 30-day supply per prescription or refill: $10 per covered preferred generic formulary drug; and 45% per covered preferred brand formulary drug.
Limited benefits: • Drugs to treat erectile dysfunction are limited up to six (6) tablets per 30-day period. Note: Mail order is not available.	**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 or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered preferred generic formulary drug; and 45% per covered preferred brand formulary drug.

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	
	Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 per covered preferred generic formulary drug; and 45% per covered preferred brand formulary drug. **Out-of-network (retail pharmacies only):** 50% plus the difference between our Plan allowance and the billed amount
Preventive care medications	
Medications to promote better health as recommended by ACA. Drugs and supplements are covered without cost-share which includes some over-the-counter, when 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 Please refer to the Aetna formulary guide for a complete list of preventive drugs including coverage details and limitations: www.aetnafeds.com/pharmacy Note: To receive this benefit a prescription from a doctor must be presented to pharmacy. Note: Preventive Medications with a USPSTF recommendation of A or B are covered without cost-share when prescribed by a health care professional and filled by a network pharmacy. These may include some over-the counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.	**In-network:** Nothing (no deductible)
Not covered: - *Drugs used for the purpose of weight reduction, such as appetite suppressants* - *Drugs for cosmetic purposes, such as Rogaine* - *Drugs to enhance athletic performance* - *Medical supplies such as dressings and antiseptics*	*All charges*

Preventive care medications - continued on next page

Benefit Description	You pay After the calendar year deductible…
Preventive care medications (cont.)	
- *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 not listed as a covered benefit, and any food item, including infant formula, medical foods and other nutritional items, even if it is the sole source of nutrition unless otherwise stated* - *Prophylactic drugs including, but no limited to, anti-malarials for travel* - *Fertility drugs* - *Compounded bioidentical hormone replacement (BHR) therapy that includes progesterone, testosterone and/or estrogen* - *Compounded thyroid hormone therapy* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation/E-cigarettes benefit. (See page 53). OTC drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 coordinating benefits with other coverage.
- The deductible is: In-network - $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment and Self and Family enrollment or Out-of-Network - $5,000 per Self Only, $10,000 for Self Plus One enrollment and Self and Family enrollment. Once an individual meets the Self Only 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 or Self and Family deductible can be satisfied by one or more family members. You must satisfy the deductible before your Traditional medical coverage may begin. 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, 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.

*** Note: If you enroll in Aetna Advantage and are covered by Medicare Part A and B and it is primary, we offer an Aetna Medicare Advantage plan to our FEHB members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage plan is subject to Medicare rules. (See page 94 for additional details.)**

Dental benefits	You Pay After the calendar year deductible...
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.
Dental benefits	
We have no other dental benefits.	

Section 5(h). 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 your 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 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.
Informed Health® Line	Provides eligible members with telephone access to registered nurses experienced in providing information on a variety of health topics. Informed Health Line is available 24 hours a day, 7 days a week. You may call Informed Health Line at 800-556-1555. We provide TDD service for the hearing and speech-impaired. We also offer foreign language translation for non-English speaking members. Informed Health Line nurses cannot diagnose, prescribe medication or give medical advice.

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.

Non-FEHB Benefits Available to Plan Members

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

Vision Discounts

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

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

Hearing Discounts

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

LifeMart® shopping website

Savings are available on travel, tickets, electronics, home, auto, family care, wellness, dining and:

- **Fitness** –gym membership, fitness gear and fitness plans
- **Weight management** –loss programs and products, diet and meal plans, and magazine subscriptions
- **Oral health care** - a variety of oral health care products

For more information, please call Aetna Member Services at **1- 800-537-9384**, or login to your member website at aetnafeds.com and select the “Stay Healthy” tab to learn more.

Natural therapy services

Try these services* at a discount. Ease your stress and tension with **massage therapy**. Heal pain or stress points with acupuncture. Relieve neck and back pain with chiropractic care. Get advice from registered dietitians with nutrition services. Find program professionals at aetnafeds.com, and just bring your Aetna ID card to your visit.

Members should log in to your member website at aetnafeds.com with your user name and password. Look for the “Stay Healthy" tab to find out more about all of the available discount programs.

* Through the ChooseHealthy® program, which is made available through American Specialty Health Administrators, Inc., a subsidiary of American Specialty Health Incorporated (ASH). ChooseHealthy is a federally registered trademark of ASH and used with permission herein.

Discount offers may be available but are not guaranteed under our contract with the FEHB program. Please see www.aetnafeds.com for details.

Section 6. General Exclusions – Services, Drugs and Supplies We Do not Cover

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

We do not cover the following:

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

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 claims for you. Your 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 person or firm providing the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply

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

In addition:

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

Records

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

Deadline for filing your claim

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

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

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

Overseas claims

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

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

Post-service claims procedures

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

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

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

When we need more information

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

Authorized Representative

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

Notice Requirements

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

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

Section 8. The Disputed Claims Process

You may appeal 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 his/her subordinate, who made the initial decision.

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Aetna 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 Employee 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 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 dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

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

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

This Plan always pays secondary to:

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

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

Note: For Motor Vehicle Accidents, charges incurred due to injuries received in an accident involving any motor vehicle for which no-fault insurance is available 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.

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

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

Recovery rights related to Workers' Compensation

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

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

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

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

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

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

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

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

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

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

Clinical trials

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan. See page 59.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs. See page 63.

- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs. See page 63.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

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

Medicare has four parts:

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

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

- **Should I enroll in Medicare?**

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

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

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

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

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

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

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

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

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

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

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

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

Please review the following table. It illustrates your cost share if you are enrolled in Medicare Parts A and B.

Aetna Advantage: (See Medicare Advantage Plan (Part C) below for the Aetna Medicare Advantage Plan option if you are enrolled in Medicare Parts A and B)

Benefit Description	You pay without Medicare	You pay with Medicare Parts A and B (primary)
Deductible	$2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment, $4,000 for Self and Family enrollment in-network	$2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment, $4,000 for Self and Family enrollment in-network
Out-of-Pocket Maximum	$7,500 Self Only/ $15,000 Self Plus One or Self and Family	$7,500 Self Only/ $15,000 Self Plus One or Self and Family
Part B Premium Reimbursement Offered	N/A	No reimbursement
Primary Care Physician	30% of Plan allowance	30% of Plan allowance
Specialist	30% of Plan allowance	30% of Plan allowance
Inpatient Hospital	30% of Plan allowance	30% of Plan allowance
Outpatient Hospital	30% of Plan allowance	30% of Plan allowance
Incentives offered	N/A	See below for how we coordinate if you opt into Aetna Medicare Advantage Part D plan.

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.

- **Medicare Advantage (Part C)**

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

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (800-633-4227), (TTY:877-486-2048) 24 hours a day/7 days a week or at www.medicare.gov.

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

This Plan and our Aetna Medicare Advantage plan: You may enroll in our national Medicare Advantage Plan if you are an annuitant or former spouse with FEHBP coverage and are enrolled in Medicare Parts A and B. **Our Medicare Advantage plan will enhance your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage plan is subject to Medicare rules**. You can enroll in our Medicare Advantage plan with no additional premium. If you are already enrolled and would like to understand your additional benefits in more detail, please refer to your Medicare plan's Evidence of Coverage. If you are enrolling in our Aetna Medicare Advantage plan, please call us at 866-241-0262 or go to www.aetnaretireehealth.com/fehbp.

Note: To receive the benefits outlined in the chart below for Aetna Medicare Advantage, you do not suspend your FEHB coverage.

By choosing this plan, retired enrollees age 65 and over with Medicare as primary coverage, agree that you have or will have Medicare Parts A and B by your effective date. You agree that you will be enrolled in our Aetna Medicare Advantage Plan. We may need more information to enroll you in this plan prior to your effective date. If this is not completed, your benefits will be significantly impacted, i.e. $2,000 deductible not waived and you will pay 30% coinsurance on most services.

This 2020 benefit summary allows you to make a side-by-side comparison:

Medical Benefit	**Aetna Advantage Plan (without Medicare)**	**Aetna Medicare Advantage Plan (with Medicare Parts A&B primary)**
Deductible	$2,000 (Self Only)/$4,000 (Self Plus One or Self and Family)	$0
Coinsurance (medical)	30% of the Plan allowance	0% of the Plan allowance
Catastrophic Maximum	$7,500 (Self Only)/$15,000 (Self Plus One or Self and Family)	$6,350 per person
Professional visit (PCP/ Specialist)	30% of Plan allowance	0% of the Plan allowance
Telehealth	$40 until the deductible is met, 30% of the $40 consult fee thereafter.	0% of the Plan allowance
Preventive care (adult/child)	$0	$0
Surgical care	30% of Plan allowance	0% of Plan allowance
Inpatient hospital	30% of Plan allowance	0% of Plan allowance
Outpatient	30% of Plan allowance	0% of Plan allowance
Emergency Room/Urgent Care	30% of Plan allowance	0% of Plan allowance
Pharmacy Tier 1 (30-day supply)	$10	$2
Pharmacy Tier 2 (30-day supply)	45%	$10
Pharmacy Tier 3 (30-day supply)	N/A	$40
Pharmacy Tier 4 (30-day supply)	N/A	$75
Pharmacy Tier 5 (30-day supply)	N/A	25% up to $350

Additional Programs that come with our Aetna Medicare Advantage Plan:

SilverSneakers®

An overall wellness program that may help members improve their health and live the life they want. The program gives members access to exercise equipment, classes, and fun social activities at thousands of locations nationwide.

Hearing aid reimbursement

Reimbursement is $2,000/every 36 months

Resources For Living

Aetna signature program which helps you find the resources you need in your daily lives. With just one call, a life consultant can help you find local resources to make life easier and treat your entire health, including your social and mental well-being.

Non-emergency transportation program

A program that ensures you make it to and from your doctor or hospital appointments without always having to rely on family or friends.

Important Information about your enrollment in our Aetna Medicare Advantage plan

Aetna Medicare Advantage Plan (PPO with ESA) is a Medicare contract separate from the FEHB Aetna Advantage Plan and depends on contract renewal with CMS.

Aetna Medicare is a PPO plan with a Medicare contract. Enrollment in our plans depends on contract renewal. See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area. GRP_4045_2307_M 09/2019

For a copy of your Evidence of Coverage go to www.aetnafeds.com/Advantage.

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.

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

Primary Payor Chart

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

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

Section 10. Definitions of Terms We Use in This Brochure

Calendar year

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

Catastrophic Protection

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

Aetna Advantage Plan

Self Only:

In-network: Your annual out-of-pocket maximum is $7,500.

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

Self Plus One:

In-network: Your annual out-of-pocket maximum is $15,000.

Out-of-network: Your annual out-of-pocket maximum is $20,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is $15,000.

Out-of-network: Your annual out-of-pocket maximum is $20,000.

However, certain expenses under both options do not count towards your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum. Refer to Section 4. 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; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's cancer, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan. See page 59.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs. See page 63.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes are generally covered by the clinical trials. This Plan does not cover these costs. See page 63.

Coinsurance

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

Copayment	A copayment is the fixed amount of money you pay when you receive covered services. See page 30.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Any type of care provided according to Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; or c) is a level such that you have reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Custodial care includes any type of care where the primary purpose is to attend to your daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples include assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of noninfected wounds, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by you, the general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in our sole determination, is based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, or convalescent care. Custodial care that lasts 90 days or more is sometimes known as long term care. Custodial care is not covered.
Deductible	A deductible is the fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.
Detoxification	The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.
Emergency care	An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.
Experimental or investigational services	Services or supplies that are, as determined by us, experimental. A drug, device, procedure or treatment will be determined to be experimental if: • There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or • Required FDA approval has not been granted for marketing; or • A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or • The written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or

- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

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.

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 (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.

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.

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:

Service or Supply	Plan allowance/Recognized charge
Professional services and other services or supplies not mentioned below	105% of the Medicare allowable rate
Services of hospitals and other facilities	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.	

Special terms used

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

Post-service claims

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

Pre-service claims

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

Precertification

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

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

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

Preventive care	Health care services designed for prevention and early detection of illnesses in average risk people, generally including routine physical examinations, tests and immunizations.
Reimbursement	A carrier's pursuit of a recovery is a covered individual that has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Respite care	Care furnished during a period of time when your family or usual caretaker cannot, or will not, attend to your needs. Respite care is not covered.
Subrogation	A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a worker's compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.
Urgent care	Covered benefits required in order to prevent serious deterioration of your health that results from an unforeseen illness or injury if you are temporarily absent from our service area and receipt of the health care service cannot be delayed until your return to our service area.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will 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.

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

Summary of Benefits for the Aetna Advantage Plan - 2020

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.aetnafeds.com. On this page we summarize specific expenses we cover; for more detail, look inside.
- The deductible is: In-network - $2,000 for Self Only enrollment, $4,000 for Self Plus One enrollment and Self and Family enrollment or Out-of-Network - $5,000 per Self Only, $10,000 for Self Plus One enrollment and Self and Family enrollment. Once an individual meets the Self Only 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 or Self and Family deductible can be satisfied by one or more family members. You must satisfy the deductible before your Traditional medical coverage may begin. In-network and out-of-network deductibles do not cross apply and will need to be met separately for traditional benefits to begin.
- 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.

Advantage Plan Benefits	You Pay	Page
In-network medical preventive care	Nothing	38
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.	44
In-network Teladoc provider consult Note: Teladoc is not available for phone service in Idaho (video consult only).	In-network: $40 until the deductible is met, 30% of the $40 consult fee thereafter. Out-of-network: No benefit. Must use Teladoc provider.	45
Services provided by a hospital:		
• Inpatient	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.	64
• Outpatient	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.	65
Emergency benefits:	In-network: 30% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	68

Advantage Plan Benefits	You Pay	Page
Mental health and substance use disorder treatment:	In-network: 30% of our Plan allowance Out-of-network: 50% of our Plan allowance and any difference between our allowance and the billed amount.	70
Prescription Drugs:	.	73
• Retail Pharmacy	Retail pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered preferred generic formulary drug; and 45% per covered preferred brand formulary drug. **Out-of-network (retail pharmacies only): (Out-of-network deductible applies)** 50% plus the difference between our Plan allowance and the billed amount.	75
• **Specialty Medications:** For up to a 30-day supply per prescription unit or refill	Preferred: $10 per covered preferred generic formulary drug; and 45% per covered preferred brand formulary drug.	76
• Mail order (available in-network only)	For a 31-day up to a 90-day supply per prescription or refill: $20 per covered preferred generic formulary drug; and 45% per covered preferred brand formulary drug.	75
Dental care:	No benefit	79
Vision care: In-network (only) preventive care benefits.	Nothing	50
Special features: Flexible benefits option, Informed Health Line, and Services for the deaf and hearing-impaired	Contact Plan	80
Protection against catastrophic costs (out-of-pocket maximum)**:**	In-network: Nothing after $7,500/Self Only enrollment, $15,000/Self Plus One enrollment, or $15,000/Self and Family enrollment per year. Out-of-network: Nothing after $10,000/Self Only enrollment, $20,000/Self Plus One enrollment, or $20,000/Self and Family enrollment per year. Some costs do not count toward this protection. Your deductible counts toward your out-of-pocket maximum.	31

2020 Rate Information for the Aetna Advantage 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.

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

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC and NPMHU.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on https://liteblue.usps.gov/fehb.
- **Postal Category 2 rates** apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career employees represented by the NRLCA agreement. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Service 800-877-8339

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Enrollment Code	Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Advantage Option Self Only	Z24	$160.56	$53.52	$347.88	$115.96	$51.38	$44.42
Advantage Option Self Plus One	Z26	$353.23	$117.74	$765.33	$255.11	$113.03	$97.73
Advantage Option Self and Family	Z25	$425.48	$141.83	$921.88	$307.29	$136.15	$117.72