Aetna Open Access®

www.aetnafeds.com

Customer service 800-537-9384

aetna®

2025

A Health Maintenance Organization (High and Basic Option)

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

Serving: Delaware, New Jersey, New York, and Pennsylvania.

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

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

IMPORTANT
- Rates: Back Cover
- Changes for 2025: Page 19
- Summary of Benefits: Page 109

Enrollment codes for NYC Upstate NY:

JC1 High Option - Self Only
JC3 High Option - Self Plus One
JC2 High Option - Self and Family

JC4 Basic Option - Self Only
JC6 Basic Option - Self Plus One
JC5 Basic Option - Self and Family

Enrollment codes for DE, Southern NJ, Philadelphia, SE PA:

P31 High Option - Self Only
P33 High Option - Self Plus One
P32 High Option - Self and Family

P34 Basic Option - Self Only
P36 Basic Option - Self Plus One
P35 Basic Option - Self and Family

Enrollment codes for Northern NJ:

JR1 High Option - Self Only
JR3 High Option - Self Plus One
JR2 High Option - Self and Family

JR4 Basic Option - Self Only
JR6 Basic Option - Self Plus One
JR5 Basic Option - Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

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

Important Notice from Aetna About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

Potential Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

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

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

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

Table of Contents

Introduction

This brochure describes our Open Access Plans (High and Basic options) under our Aetna* contract (CS 2914) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 800-537-9384 or through our website: www.AetnaFeds.com. The address for the Aetna administrative office is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2025, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2025, and changes are summarized in Section 2. Rates are shown at the end of this brochure.

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

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

Plain Language

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

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

Stop Healthcare Fraud!

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

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements 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 800-537-9384 and explain the situation.
  - If we do not resolve the issue:

CALL- THE HEALTH CARE FRAUD HOTLINE

877-499-7295

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

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

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

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

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, for example a member's gender identity or the fact that the covered benefit is sought in connection with gender-affirming care, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

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

1. **Ask questions if you have doubts or concerns.**

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

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

- Bring the actual medications or give your doctor and pharmacist a list of all the medication 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 reactions 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.ahrq.gov/consumer/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- https://psnet.ahrq.gov/issue/national-patient-safety-foundation. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard (MVS)**

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

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

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

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

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

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

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

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

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

  Self Only coverage is only for the enrollee. Self Plus One coverage for the enrollee and one eligible family member. Self and Family coverage is for the enrollee, and one or more eligible family members. Family members include your spouse, and your 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.

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

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

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

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

- **Family member coverage**

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

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

Foster children
Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

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

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

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, 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 2025 benefits of your prior plan or option. If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option.** However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2024 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at: https://www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

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

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

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

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

- **Converting to individual coverage**

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

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

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-537-9384 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 a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory or visit our website at www.AetnaFeds.com. We give you a choice of enrollment in a High Option or a Basic Option.

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

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

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

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

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

General features of our High and Basic Options

- You can see participating network specialists without a referral (Open Access).
- You can choose between our Basic Dental or Dental PPO option. Under Basic Dental, you can access preventive care for a $5 copay and other services at a reduced fee. Under the PPO option, if you see an in-network dentist, you pay nothing for preventive care after a $20 annual deductible per member. You may also utilize non-network dentists for preventive care, but at reduced benefit levels after satisfying the $20 annual deductible per member. You pay all charges for other services when utilizing non-network dentists.
- You receive up to a $100 reimbursement every 24 months for glasses or contact lenses under the High Option and up to a $200 reimbursement every 24 months under the Basic Option.

We have Open Access benefits

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

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

How we pay providers

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

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

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

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

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

Your rights and responsibilities

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

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

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

If you want more information about us, call 800-537-9384 or write to Aetna at P.O. Box 818047, Cleveland, OH 44181-8047. You may also visit our website at www.AetnaFeds.com.

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

Your medical and claims records are confidential

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

Medical Necessity

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

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

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

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

Direct Access Ob/Gyn Program

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

Mental Health/Substance Misuse

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

Ongoing Reviews

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

Authorization

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

Patient Management

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

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

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

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

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

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

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

Member Services

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

- Ask questions about benefits and coverage.
- Notify us of changes in your name, address or phone number.
- Change your primary care provider or office.
- 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 OK 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.

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

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

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

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

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

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

- For workers' compensation purposes
- As required by law
- About people who have died
- For organ donation
- To fulfill our obligations for individual access and HIPAA compliance and enforcement

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 800-537-9384, or write to Aetna, Federal Plans, PO Box 818047, Cleveland, OH 44181-8047. You may also contact us by fax at 860-975-1669 or visit our website at www.AetnaFeds.com.

Service Area

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

Delaware - Enrollment code **P3** - Kent, New Castle, and Sussex counties.

New Jersey, Northern – Enrollment code **JR** – Bergen, Essex, Hudson, Hunterdon, Middlesex, Monmouth, Morris, Ocean, Passaic, Somerset, Sussex, Union and Warren counties.

New Jersey, Southern – Enrollment code **P3** – Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Mercer and Salem counties.

New York, The Greater New York City area and Upstate New York – Enrollment code **JC** – Bronx, Broome, Cayuga, Dutchess, Kings (Brooklyn), Nassau, New York (Manhattan), Onondaga, Orange, Oswego, Putnam, Queens, Richmond (Staten Island), Rockland, Suffolk, Sullivan, Tioga, Ulster and Westchester counties.

Pennsylvania, Philadelphia, and Southeastern PA – Enrollment code **P3** – Berks, Bucks, Carbon, Chester, Delaware, Lehigh, Monroe, Montgomery, Northampton, and Philadelphia counties.

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

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

Section 2. Changes for 2025

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

Changes to High Option only

- **Enrollment Code JC.** Your share of the premium rate will increase for Self Only, increase for Self Plus One, and increase for Self and Family. (See Rate Information)
- **Enrollment Code P3**. Your share of the premium rate will decrease for Self Only, decrease for Self Plus One, and decrease for Self and Family. (See Rate Information)
- **Enrollment Code JR.** Your share of the premium rate will increase for Self Only, increase for Self Plus One, and increase for Self and Family. (See Rate Information)

Changes to Basic Option only

- **Enrollment Code JC.** Your share of the premium rate will increase for Self Only, increase for Self Plus One, and increase for Self and Family. (See Rate Information)
- **Enrollment Code P3.** Your share of the premium rate will decrease for Self Only, decrease for Self Plus One, and decrease for Self and Family. (See Rate Information)
- **Enrollment Code JR.** Your share of the premium rate will increase for Self Only, increase for Self Plus One, and increase for Self and Family. (See Rate Information)

Changes under both High and Basic Options

- **Services that require plan approval (other services)** – The Plan updated its list of services that require plan approval. (See Section 3, You need prior Plan approval for certain services)

Section 3. How You Get Care

Open Access HMO

This Open Access Plan is available to our members in those FEHBP service areas identified in Section 1. You can go directly to any network specialist for covered services without a referral from your primary care provider. Whether your covered services are provided by your selected primary care provider (for your PCP copay) or by any other participating provider in the network (for the specialist copay), you will be responsible for payment which may be in the form of a copay (flat dollar amount) or coinsurance (a percentage of covered expenses). While not required, it is highly recommended that you still select a PCP and notify Member Services of your selection (800-537-9384). **If you go directly to a specialist, you are responsible for verifying that the specialist is participating in our Plan. If your participating specialist refers you to another provider, you are responsible for verifying that the other specialist is participating in our Plan.**

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-537-9384 or write to us at Aetna, P.O. Box 14079, Lexington, KY 40512-4079. You may also request replacement cards through our Aetna member website at www.AetnaFeds.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. You will not have to file claims. If you use our Open Access program you can receive covered services from a participating network provider without a required referral from your primary care provider or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. Services by Plan Providers are covered when acting within the scope of their license or certification under applicable state law. We credential Plan providers according to national standards.

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

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

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at www.AetnaFeds.com for assistance.

- **Plan facilities**

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

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

What you must do to get covered care

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

- **Primary care**

  Your primary care provider can be a general practitioner, family practitioner, internist or pediatrician. Your primary care provider will provide or coordinate most of your health care.

  If you want to change primary care providers or if your primary care provider leaves the Plan, call us or visit our website. We will help you select a new one.

- **Specialty care**

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

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

  - If you are seeing a specialist when you enroll in our Plan, talk to your primary care provider. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
  - If you are seeing a specialist and your specialist leaves the Plan, call your primary care provider, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
  - If you have a chronic and disabling condition and lose access to your specialist because we:
    - terminate our contract with your specialist for other than cause;
    - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Program plan; or
    - reduce our Service Area and you enroll in another FEHB plan;

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

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

- **Hospital care**

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

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

  We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 800-537-9384. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

Since your primary care provider 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**

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

- Inpatient confinements (except hospice) - For example, surgical and nonsurgical stays; stays in a skilled nursing facility or rehabilitation facility; and maternity and newborn stays that exceed the standard length of stay (LOS)
- Ambulance - Precertification required for transportation by fixed-wing aircraft (plane)
- Autologous chondrocyte implantation
- Cataract surgery
- 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 affirming surgery
- Functional endoscopic sinus surgery
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- In-network infertility services and pre-implantation genetic testing

- 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
- Site of Service - when requested at an Outpatient hospital setting and when is one of the following:
  - Anal fistula surgery
  - Ankle ligament repair
  - Arthrocentesis
  - Breast tissue excision
  - Carpal tunnel surgery
  - Circumcision - older than 28 days of age
  - Colposcopy
  - Carpal tunnel surgery
  - Complex wound repair
  - Conization of cervix
  - Cystourethroscopy
  - Dilation and curettage (D&C)
  - Esophagogastroduodenoscopy (EGD)
  - Excision of lesion of tendon sheath or joint capsule
  - Ganglion excision
  - Hemorrhoidectomy
  - Hernia repair
  - Hydrocele excision
  - Hysteroscopy
  - Implant removal (i.e., screw)
  - Intranasal dermatoplasty
  - Intravitreal injection
  - Iridotomy/iridectomy, laser surgery

  - Knee joint manipulation under general anesthesia
  - Laparoscopic cholecystectomy
  - Laparoscopy, diagnostic
  - Laryngoscopy
  - Lithotripsy
  - Mohs surgery
  - Nasal bone fracture, closed treatment
  - Neuroplasty, ulnar
  - Orchiopexy
  - Penile angulation correction
  - Prostate biopsy
  - Septoplasty
  - Skin tissue transfer or rearrangement
  - Subcutaneous soft tissue excision
  - Tendon sheath incision
  - Tenodesis of long tendon of biceps
  - Tonsillectomy (age 12 or older)
  - Transurethral electrosurgical resection of prostate (TURP)
  - Trigger point injections
  - Turbinate resection
  - Tympanostomy
- Spinal procedures, such as:
  - Artificial intervertebral disc surgery (cervical spine)
  - Arthrodesis for spine deformity
  - Cervical laminoplasty
  - ervical, lumbar and thoracic laminectomy/laminotomy procedures
  - Kyphectomy
  - Laminectomy with rhizotomy
  - Removal of spinal instrumentation
  - Sacroiliac joint fusions
  - Spinal fusion surgery
  - Vertebral corpectomy
  - Vertebroplasty/Kyphoplasty
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices
- 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 and interferons when used for hepatitis C)*

- Special Programs (including but not limited to BRCA genetic testing, Chiropractic precertification, Diagnostic Cardiology (Cardiac rhythm implantable devices, cardiac catheterization), Hip and knee arthroplasties, National Medical Excellence Program®, Pain management, Peripheral Arterial Disease, 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: 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

Members must call 800-537-9384 for authorization.

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

First, your physician, your hospital, you, or your representative, must call us at 800-537-9384 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

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

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

- **Urgent care claims**

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

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

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

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

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

- **Maternity care**

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

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

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

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

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

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

- **To file an appeal with OPM**

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

Section 4. Your Cost for Covered Services

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

Cost-sharing

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

Copayments

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

Example: When you see your primary care provider, you pay a copayment of $20 per office visit, or a copayment of $35 per office visit when you see a participating specialist under High Option and a copayment of $15 per office visit to your primary care provider, or a copayment of $35 per office visit when you see a participating specialist under Basic Option.

Deductible

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

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

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

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

Coinsurance

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

Example: In our Plan, you pay 30% of our allowance for 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 (for Dental PPO Option only): If you use a non-network provider for preventive dental care, you will have to pay 50% of our negotiated rate and the difference between our Plan allowance and the billed amount.
- You should also see section Important Notice About Surprise Billing – Know Your Rights below that describes your protections against surprise billing under the No Surprises Act.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $5,000 for Self Only or $10,000 for Self Plus One, or $10,000 for Self and Family enrollment for the High Option and $7,000 for Self Only or $12,000 for Self Plus One, or $12,000 for Self and Family enrollment for the Basic Option in any calendar year, you do not have to pay any more for covered 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. However, copayments and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Dental services (Note: $5 copayments for DMO preventive care and $20 deductible for PPO preventive care count towards your out-of-pocket maximum. All other dental service expenses do not count toward your out-of-pocket maximum).

- Infertility services covered under the medical benefit

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

Carryover

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

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

When Government facilities bill us

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

Important Notice About Surprise Billing – Know Your Rights

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

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

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

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

Please note: There are certain circumstances under the law where a provider can give you notice that they are out of network and you can consent to receiving a balance bill. For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.AetnaFeds.com or contact the health plan at 800-537-9384.

The Federal Flexible Spending Account Program – *FSAFEDS*

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

Section 5. High and Basic Option Benefits

See Section 2 for how our benefits changed this year. See Summary of Benefits for a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. High and Basic Option Benefits Overview

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

The High and Basic Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also, read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Basic Option benefits, contact us at 800-537-9384 or on our website at www.AetnaFeds.com.

The High and Basic Options offer the same unique features but at different copays:

- You can see participating network specialists without a referral (Open Access).
- You have more choices for your dental coverage. You can choose between our Advantage Dental or Dental PPO option. Under Advantage Dental, you can access preventive care for a $5 copay and other services at a reduced fee. Under the PPO option, if you see an in-network dentist, you pay nothing for preventive care after a $20 annual deductible per member. Participating network PPO dentists may offer members other services at discounted fees. Discounts may not apply in all states. You may also utilize non-network dentists for preventive care, but at reduced benefit levels, and after a $20 annual deductible per member. You pay all charges for other services when utilizing non-network dentists.
- You receive up to a $100 reimbursement every 24 months for glasses or contact lenses under the High Option and up to a $200 reimbursement every 24 months under the Basic Option.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- If you live or work in an Aetna Open Access HMO service area, you should select a PCP by calling Member Services at 800-537-9384.
- If you live or work in an Aetna Open Access HMO service area, you do not have to obtain a referral from your PCP to see a specialist.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).

Benefit Description	You pay	
Diagnostic and treatment services	**High**	**Basic**
Professional services of physicians • In physician's office - Office medical evaluations, examinations, and consultations - Second surgical or medical opinion	$20 per primary care provider (PCP) visit $35 per specialist visit	$15 per primary care provider (PCP) visit $35 per specialist visit
• During a hospital stay • In a skilled nursing facility	Nothing	Nothing
• In an urgent care center	$50 per visit	$100 per visit
• At home	$25 per PCP visit $35 per specialist visit	$20 per PCP visit $35 per specialist visit
Telehealth services	**High**	**Basic**
• Teladoc Health consult	$35 per consult	$35 per consult
• CVS Health Virtual Care™ consult	$0 per consult	$0 per consult
Please see www.AetnaFeds.com/Tools.php for information on medical and behavioral telehealth services. Members will receive a welcome kit explaining the telehealth benefits. Refer to Section 5(e) for behavioral health telehealth consults.		

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests	**High**	**Basic**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and electroencephalogram (EEG) • Sleep studies	Nothing if your physician performs and bills for the lab work; otherwise if lab work is performed by another physician or the specimen is sent to an independent lab. $20 per PCP visit $35 per specialist visit	Nothing if your physician performs and bills for the lab work; otherwise if lab work is performed by another physician or the specimen is sent to an independent lab. $15 per PCP visit $35 per specialist visit
Diagnostic tests limited to: • Bone density tests-diagnostic • CT scans/MRIs/PET scans • Diagnostic angiography • Genetic testing-diagnostic* • Nuclear medicine Note: The services need precertification. See Section 3 "Services requiring our prior approval". *Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's medical condition.	$75 copay	$75 copay
Genetic Counseling and Evaluation for BRCA Testing Genetic Testing for BRCA-Related Cancer * * Note: Requires precertification. See Section 3 "Services requiring our prior approval".	Nothing	Nothing
Preventive care, adult	**High**	**Basic**
• Routine physicals - one (1) exam every calendar year. The following preventive services are covered at the time interval recommended at each of the links below. • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • Adult Immunizations endorsed by the Centers for Disease Control (CDC): based on the Advisory Committee on Immunization Practices (ACIP) schedule. for a complete list of endorsed immunizations go to the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules/	Nothing	Nothing

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High**	**Basic**
• Individual counseling on prevention and reducing health risks • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women please visit the Health and Human Services (HHS) website at https://www.hrsa.gov/womens-guidelines • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Some tests provided during a routine physical may not be considered preventive. Contact member services at 800-537-9384 for information on whether a specific test is considered routine.	Nothing	Nothing
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, limited to 26 visits per person per calendar year • Counseling programs when medically identified to support obesity prevention and management by an in-network provider Note: For anti-obesity medications prescribed as indicated by the FDA chronic weight management guidelines, see Section 5(f), *Prescription drug benefits.* Note: When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	Nothing	Nothing
Routine mammogram • One (1) every calendar year; or when medically necessary	Nothing	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing
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*	*All charges*

Benefit Description	You pay	
Preventive care, children	**High**	**Basic**
• Well-child visits, examinations, and immunizations other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Children's immunizations endorsed by the Centers for Disease Control (CDC) including DTaP/Tdap, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the website at https://www.cdc.gov/vaccines/schedules/index.html • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Some tests provided during a routine physical may not be considered preventive. Contact member services at 800-537-9384 for information on whether a specific test is considered routine.	Nothing	Nothing
• 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 Examinations such as: • Vision screenings through age 17 to determine the need for vision correction* • Hearing exams through age 17 to determine the need for hearing correction • Routine examinations done on the day of immunizations (up to age 22) *For routine eye refraction, see Vision Services Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High**	**Basic**
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to comprehensive, intensive nutrition and behavioral weight-loss therapy and counseling programs under the USPSTF A and B recommendations. These programs are covered as part of prevention and treatment of obesity as follows: • Comprehensive, intensive nutrition and behavioral weight-loss counseling therapy. • When anti-obesity medication is prescribed as indicated by the FDA obesity medication treatment guidelines. See Section 5(f) for cost share requirements for anti-obesity medications. • When Bariatric or Metabolic surgical treatment or intervention is indicated for severe obesity. See Section 5(b) for surgery requirements and cost share.	Nothing	Nothing
Not covered: • *Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.*	*All charges*	*All charges*
Maternity care	**High**	**Basic**
Complete maternity (obstetrical) care, such as: • Routine Prenatal care - includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. • Screening and counseling for prenatal and postpartum depression Note: Items not considered routine include: (but not limited to) - Amniocentesis - Certain Pregnancy diagnostic lab tests - Delivery including Anesthesia - Fetal Stress Tests - High Risk Specialist Visits - Inpatient admissions - Ultrasounds • Screening for gestational diabetes • Delivery • Postnatal care 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.	No copay for routine prenatal care or the first postpartum care visit $20 for PCP visit or $35 for specialist visits for postpartum care visits thereafter Note: If your PCP or specialist refers you to another specialist or facility for additional services, you pay the applicable copay for the service rendered.	No copay for routine prenatal care or the first postpartum care visit $15 for PCP visit or $35 for specialist visits for postpartum care visits thereafter Note: If your PCP or specialist refers you to another specialist or facility for additional services, you pay the applicable copay for the service rendered.

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High**	**Basic**
• As part of your coverage, you have access to in-network certified nurse midwives, home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. To enroll in the Enhanced Maternity program, call toll-free 800-272-3531. • You may remain in the hospital up to three (3) days after a vaginal delivery and five (5) days after a cesarean delivery. We will extend your inpatient stay if medically necessary, but you, your representative, your participating doctor, or your hospital must precertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay including the initial examination of a newborn child covered under a family enrollment. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Only, Self Plus One or Self and Family enrollment. • We pay hospitalization and surgeon services for maternity care (delivery) the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: Also see our Enhanced Maternity Program in Section 5(h). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. In addition, circumcision is covered at the same rate as for regular medical or surgical benefits.	No copay for routine prenatal care or the first postpartum care visit $20 for PCP visit or $35 for specialist visits for postpartum care visits thereafter Note: If your PCP or specialist refers you to another specialist or facility for additional services, you pay the applicable copay for the service rendered.	No copay for routine prenatal care or the first postpartum care visit $15 for PCP visit or $35 for specialist visits for postpartum care visits thereafter Note: If your PCP or specialist refers you to another specialist or facility for additional services, you pay the applicable copay for the service rendered.
Breastfeeding and lactation support, supplies and counseling for each birth	Nothing	Nothing
Not covered: Home births	*All charges*	*All charges*
Family planning	**High**	**Basic**
A range of voluntary family planning services, without cost sharing, that includes at least one form of contraception in each of the categories on the HRSA list. This list includes: • Voluntary female sterilization • Contraceptive counseling on an annual basis • Surgically implanted contraceptives • Generic injectable contraceptive drugs • Intrauterine devices (IUDs) • Diaphragms Note: See additional Family Planning and Prescription drug coverage Section 5(f).	Nothing	Nothing

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**High**	**Basic**
Note: Your plan offers some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost. Visit www.AetnaFeds.com/FamilyPlanning.php for more information on contraception and the exception process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Note: We cover injectable contraceptives under the medical benefit when supplied by and administered at the provider's office. Injectable contraceptives are covered at the prescription drug benefit when they are dispensed at the Pharmacy. If a member must obtain the drug at the pharmacy and bring it to the provider's office to be administered, the member would be responsible for both the Rx and office visit copayments. We cover oral contraceptives under the prescription drug benefit.	Nothing	Nothing
• Voluntary male sterilization (See Surgical procedures Section 5 (b))	$20 per PCP visit $35 for Specialist visit	$15 per PCP visit $35 for Specialist visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*	*All charges*
Infertility services	**High**	**Basic**
Infertility is a disease defined as when a person is unable to conceive or produce conception after one year of egg-sperm contact when the individual attempting conception is under 35 years of age, or after six months of egg-sperm contact when the individual attempting conception is 35 years of age or older. Egg-sperm contact can be achieved by regular sexual intercourse or artificial insemination (intrauterine, intracervical, or intravaginal) as stated in our medical clinical policy bulletin (see Section 10. for definition of Medical Necessity for additional details on Aetna's Clinical Policy). This definition applies to all individuals regardless of sexual orientation or the presence/availability of a reproductive partner. Infertility may also be established by the demonstration of a disease or condition of the reproductive tract such that egg-sperm contact would be ineffective. Diagnosis and treatment of infertility such as: • Testing for diagnosis and surgical treatment of the underlying medical cause of infertility. • Fertility preservation procedures (retrieval of and freezing of eggs or sperm) for members facing the possibility of infertility caused by chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or ovary or testicle removal for treatment of disease.* ** • Artificial insemination (AI)* ** and monitoring of ovulation:	50% of all charges Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details)	50% of all charges Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details)

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High**	**Basic**
- Intracervical insemination (ICI) - Intrauterine insemination (IUI) - Intravaginal insemination (IVI) We limit Artificial Insemination cycles and Ovulation Induction cycles to 3 cycles total per calendar year. The Plan defines a "cycle" as: • An artificial insemination cycle with or without injectable medication to stimulate the ovaries • Ovulation induction cycle(s) while on injectable medication (including but not limited to menotropins, hCG, GnRH) to stimulate the ovaries. *(See Section 5(f) for coverage) • Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician * • Injectable fertility drugs including but not limited to menotropins, hCG, and GnRH agonists. (See Section 5(f) for coverage)* You are eligible for covered Ovulation Induction medication cycles if: • You or your partner have been diagnosed with infertility. • You have met the requirement for the number of months trying to conceive through egg and sperm contact. • Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's infertility clinical policy. Note: Please see Section 5(f) for coverage of infertility drugs. **Aetna's National Infertility Unit** Our NIU is here to help you and is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with understanding your benefits and the medical precertification process. You can learn more at www.AetnaInfertilityCare.com or call the NIU at 1-800-575-5999 (TTY: 711). * Subject to medical necessity ** Note: Requires Precertification. See Section 3 "Services requiring our prior approval". You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 800-537-9384. Your network provider will request approval from us in advance for your infertility services. If your provider is not a network provider, you are responsible to request approval from us in advance.	50% of all charges Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details)	50% of all charges Note: Your out of pocket costs for infertility services do not count towards your out-of-pocket maximum (See Section 4 for details)
Not covered: • *All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to:*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High**	**Basic**
- *Imaging, laboratory services, and professional services* - *In vitro fertilization (IVF)* - *Zygote intrafallopian transfer (ZIFT)* - *Gamete intrafallopian transfer (GIFT)* - *Cryopreserved embryo transfers* - *Gestational carrier cycles* - *Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).* • *Cryopreservation (freezing), storage or thawing of eggs, embryos, sperm or reproductive tissue (unless noted as covered)* • *All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father* • *Any charges associated with care required to obtain ART services (e.g. office, hospital, ultrasounds, laboratory tests, etc); and any charges associated with obtaining sperm for ART procedures except as stated above* • *The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier* • *Reversal of sterilization surgery* • *Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization* • *Services and supplies related to the above mentioned services, including sperm processing* • *Cost of home ovulation predictor kits or home pregnancy kits* • *Drugs related to the treatment of non-covered benefits* • *Infertility services that are not reasonably likely to result in success* • *Elective fertility preservation, such as egg freezing sought due to natural aging* • *Infertility treatments such as in vitro fertilization that might be needed after the necessary medical intervention* • *Storage costs* • *Obtaining sperm from a person not covered under this plan* • *Infertility treatment when a successful pregnancy could have been obtained through less costly treatment*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High**	**Basic**
• *Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g. perimenopause, menopause)as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy* • *Oral and Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists. (except where otherwise noted in Section 5f)* • *Any infertility service rendered that requires precertification without a prior authorization* • *Coverage for services received by a spouse or partner who is not a covered member under the plan*	*All charges*	*All charges*
Allergy care	**High**	**Basic**
• Testing and treatment • Allergy injections Note: You pay the applicable copay for each visit to a doctor's office including each visit to a nurse for an injection.	$20 per PCP visit $35 per specialist visit	$15 per PCP visit $35 per specialist visit
• Allergy serum	Nothing	Nothing
Not covered: • *Provocative food testing* and *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High**	**Basic**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants in Section 5(b). • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis Note: Copayment does not apply for peritoneal dialysis when self administered. Copayment will apply if services are rendered in the home by a plan provider. • Intravenous (IV) Infusion Therapy in a doctor's office or facility (For IV infusion and antibiotic treatment at home, see Home Health Services.) • Growth hormone therapy (GHT) Note: Growth hormone therapy is covered under Medical Benefits; office copay applies. We cover growth hormone injectables under the prescription drug benefit.	$35 per visit Note: If you receive these services during an inpatient admission, then facility charges will apply. See section 5(c) for applicable facility charges.	$35 per visit Note: If you receive these services during an inpatient admission, then facility charges will apply. See section 5(c) for applicable facility charges.

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High**	**Basic**
Note: We will only cover GHT when we preauthorize the treatment. Call 800-245-1206 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and it is authorized by Aetna. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$35 per visit Note: If you receive these services during an inpatient admission, then facility charges will apply. See section 5(c) for applicable facility charges.	$35 per visit Note: If you receive these services during an inpatient admission, then facility charges will apply. See section 5(c) for applicable facility charges.
Physical and occupational therapies	**High**	**Basic**
Sixty (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 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)	$35 per visit Nothing during a covered inpatient admission Note: If you receive these services during an inpatient admission or outpatient visit, then facility charges will apply. See section 5(c) for applicable facility charges.	$35 per visit Nothing during a covered inpatient admission Note: If you receive these services during an inpatient admission or outpatient visit, then facility charges will apply. See section 5(c) for applicable facility charges.
Not covered: • *Long-term rehabilitative therapy*	*All charges*	*All charges*
Pulmonary and cardiac rehabilitation	**High**	**Basic**
• Two (2) consecutive months (60 consecutive days) per condition per member per calendar year for pulmonary rehabilitation to treat functional pulmonary disability. • Cardiac rehabilitation following a qualifying event/condition is provided for up to three (3) visits a week for a total of 18 visits.	$35 per visit Nothing during a covered inpatient admission	$35 per visit Nothing during a covered inpatient admission
Not covered: Long-term rehabilitative therapy	*All charges*	*All charges*

Benefit Description	You pay	
Habilitative therapy	**High**	**Basic**
• Habilitative services for congenital or genetic birth defects including, but not limited to, autism or an autism spectrum disorder, and developmental delays. Treatment is provided to enhance the ability to function. Services include occupational therapy, physical therapy and speech therapy.	$35 per visit Nothing during a covered inpatient admission	$35 per visit Nothing during a covered inpatient admission
Speech therapy	**High**	**Basic**
• 60 visits per person, per calendar year	$35 per visit Nothing during a covered inpatient admission	$35 per visit Nothing during a covered inpatient admission
Hearing services (testing, treatment, and supplies)	**High**	**Basic**
• Audiological testing and medically necessary treatment for hearing problems • Hearing testing for children through age 17 (see *Preventive care, children*) • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. (See *Orthopedic and prosthetic devices* section and the note referring to Section 5(b) and 5(c) for hospital and ambulatory surgery center benefits). Note: 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. Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$20 per PCP visit $35 per specialist visit	$15 per PCP visit $35 per specialist visit
Not covered: • *Hearing aids, testing and examinations for them* • *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High**	**Basic**
• Treatment of eye diseases and injury.	$20 per PCP visit $35 per specialist visit	$15 per PCP visit $35 per specialist visit
• Corrective eyeglasses and frames or contact lenses (hard or soft) for adults age 19 and older once per 24 month period.	All charges over $100	All charges over $200
• Corrective eyeglasses and frames or contact lenses (hard or soft) for children through age 18 once per 24 month period. Note: You must pay for charges above the $100 allowance for high option or $200 allowance for basic option and submit a claim form for reimbursement of the 10%.	90% of charges after $100	90% of charges after $200
• One (1) routine eye exam (including refraction) every 12 month period	$35 per specialist visit	$35 per specialist visit
Not covered:	*All charges*	*All charges*

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

Benefit Description	You pay	
Vision services (testing, treatment, and supplies) (cont.)	**High**	**Basic**
• *Fitting of contact lenses* • *Vision therapy, including eye patches and eye exercises, e.g., orthoptics, pleoptics, for the treatment of conditions related to learning disabilities or developmental delays* • *Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors*	*All charges*	*All charges*
Foot care	**High**	**Basic**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$20 per PCP visit $35 per specialist visit	$15 per PCP visit $35 per specialist visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot (see Foot care), except as stated above* • *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open manipulation or fixation)* • *Foot orthotics* • *Podiatric shoe inserts*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High**	**Basic**
• Orthopedic devices such as braces and prosthetic devices such as artificial limbs and eyes. Limb and torso prosthetics must be preauthorized. • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, bone anchored hearing aids (BAHA), penile implants, defibrillator, surgically implanted breast implant following mastectomy, and lenses following cataract removal. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Ostomy supplies specific to ostomy care (quantities and types vary according to the ostomy, location, construction, etc.) Note: Coverage includes repair and replacement when due to growth or normal wear and tear. Note: Certain devices require precertification by you or your physician. Please see Section 3 for a list of services that require precertification. Note: For information on the professional charges for the surgery to insert an implant, or internal prosthetic device, see Section 5(b) Surgical procedures. For information regarding facility fees associated with obtaining orthopedic and prosthetic devices, see Section 5(c).	30% of our Plan allowance	30% of our Plan allowance

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High**	**Basic**
• Hair prosthesis prescribed by a physician for hair loss resulting from radiation therapy, chemotherapy or certain other injuries, diseases, or treatment of a disease.	Nothing up to Plan lifetime maximum of $500	Nothing up to Plan lifetime maximum of $500
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups* • *Lumbosacral supports* • *All charges over $500 for hair prosthesis*	*All charges*	*All charges*
Durable medical equipment (DME)	**High**	**Basic**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Contact Plan at 800-537-9384 for a complete list of covered DME. Some covered items include: • Oxygen • Dialysis equipment • Hospital beds (Clinitron and electric beds must be preauthorized) • Wheelchairs (motorized wheelchairs and scooters must be preauthorized) • Crutches • Walkers • Insulin pumps and related supplies such as needles and catheters • Medical foods taken for the treatment of Inborn Errors of Metabolism when provided by a participating DME provider and administered under the direction of a physician Note: You must get your DME from a participating DME provider. Some DME may require precertification by you or your physician.	30% of our Plan allowance	30% of our Plan allowance
Not covered: • *Elastic stockings and support hose* • *Bathroom equipment such as bathtub seats, benches, rails and lifts* • *Home modifications such as stair glides, elevators and wheelchair ramps* • *Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities* • *Medical foods that do not require a prescription under Federal law even if your physician or other health care professional prescribes them* • *Nutritional supplements that are not administered by catheter or nasogastric tubes, except for oral medical foods taken for the treatment of Inborn Errors of Metabolism when administered under the direction of a physician*	*All charges*	*All charges*

Benefit Description	You pay	
Home health services	**High**	**Basic**
• Home health services ordered by a Plan Physician and provided by nurses and home health aides through a participating home health care agency. Home health services include skilled nursing services provided by a licensed nursing professional; services provided by a physical therapist, occupational therapist, or speech therapist; and services of a home health aide when provided in support of the skilled home health services. Home health services are limited to one (1) visit per day with each visit equal to a period of four (4) hours or less. The Plan will allow up to 60 visits per member per calendar year. Your Plan Physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy Note: Short-term physical, speech, or occupational therapy accumulate toward the applicable benefit limit (See the physical, speech and occupational therapy benefit in this section). Note: Skilled nursing under home health services must be precertified by your Plan physician.	$90 per visit	$90 per visit
Intravenous (IV) Infusion Therapy and medications	$35 per visit	$35 per visit
Not covered: • *Nursing care for the convenience of the patient or the patient's family.* • *Custodial care, i.e. home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative and appropriate for the active treatment of a condition, illness, disease or injury.* • *Services provided by a family member or resident in the member's home.* • *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.* • *Transportation.*	*All charges*	*All charges*
Chiropractic	**High**	**Basic**
• Chiropractic services up to 20 visits per member per calendar year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electric muscle stimulation, vibratory therapy and cold pack application	$35 per specialist visit	$35 per specialist visit
Not covered: • *Any services not listed above*	*All charges*	*All charges*

Benefit Description	You pay	
Alternative medicine treatments	**High**	**Basic**
Acupuncture - 10 visits per member per calendar year (when considered medically necessary) Note: See Section 5(b) for our coverage of acupuncture when provided as anesthesia for covered surgery. See Section 5 Non-FEHB benefits available to Plan members for discount arrangements.	$20 per visit	$15 per visit
Not covered: Other alternative medical treatments including but not limited to: • *Acupuncture other than stated above* • *Applied kinesiology* • *Aromatherapy* • *Biofeedback* • *Craniosacral therapy* • *Hair analysis* • *Reflexology*	*All charges*	*All charges*
Educational classes and programs	**High**	**Basic**
Aetna 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 • Depression • Cystic Fibrosis • Diabetes • Hepatitis • Inflammatory bowel disease • Kidney failure • Low back pain • Sickle Cell disease To request more information on our disease management programs, call 800-537-9384.	Nothing	Nothing
Coverage is provided for: • Tobacco cessation program including individual, group, phone counseling, physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat nicotine dependence.	Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year.	Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year.

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High**	**Basic**
Note: Over-the-counter (OTC) drugs will not be covered unless you have a prescription and the prescription is presented at the pharmacy and processed through our pharmacy claim system.	Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for over-the-counter (OTC);drugs and prescription drugs approved by the FDA to treat nicotine dependence.	Nothing for four (4) smoking cessation counseling sessions per quit attempt and two (2) quit attempts per year. Nothing for over-the-counter (OTC) drugs and prescription drugs approved by the FDA to treat nicotine dependence.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e., hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	
Surgical procedures	**High**	**Basic**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of severe obesity (bariatric surgery) – a condition in which an individual has a body mass index (BMI) exceeding 40 or a BMI greater than 35 in conjunction with documented significant co-morbid conditions (such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea, nonalcoholic steatohepatitis (NASH) or refractory hypertension).** - Members must have attempted weight loss in the past without successful long-term weight reduction; and Members must have participated in and been compliant with an intensive multicomponent behavioral intervention through a combination of dietary changes and increased physical activity for 12 or more sessions occurring within two (2) years prior to surgery. Blood glucose control must be optimized, and psychological clearance may be necessary.	$20 per PCP visit $35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$15 per PCP visit $35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High**	**Basic**
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 affirming surgery* - The Plan will provide coverage for the following when the member meets Plan criteria: • Surgical removal of breasts** • Breast augmentation (implants/lipofilling)** • Surgical removal of uterus, ovaries and testes** • Reconstruction of external genitalia** • Medically necessary facial gender affirming surgery and body contouring (Note: For more information on coverage details for medically necessary facial and body contouring coverage and criteria, please refer to www.AetnaFeds.com/Gender-Affirming-Care) * Note: Requires Precertification. See Section 3 “Services requiring our prior approval”. You are responsible for ensuring that we are asked to precertify your care; you should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 800-537-9384. ** Subject to medical necessity based on our clinical policy bulletin.	$20 per PCP visit $35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$15 per PCP visit $35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High**	**Basic**
Note: Hormone therapy is covered under Section 5(f), Prescription drug benefits. Prior authorization is required.	$20 per PCP visit $35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$15 per PCP visit $35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.
Voluntary sterilization for women (e.g., tubal ligation)	Nothing	Nothing
Not covered: • *Reversal of voluntary surgically-induced sterilization* • *Surgery primarily for cosmetic purposes* • *Radial keratotomy and laser surgery, including related procedures designed to surgically correct refractive errors* • *Gender reassignment services that are not considered medically necessary* • *Routine treatment of conditions of the foot (see Foot care)*	*All charges*	*All charges*
Reconstructive surgery	**High**	**Basic**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital and developmental anomalies are cleft lip, cleft palate, webbed fingers, and webbed toes. All surgical requests must be preauthorized. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications, such as lymphedema - breast prostheses and surgical bras and replacements (*see Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High**	**Basic**
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High**	**Basic**
Oral surgical procedures, that are medical in nature, such as: • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ (must be preauthorized); • Excision of tumors and cysts; and • Removal of bony impacted wisdom teeth. Note: When requesting oral and maxillofacial services, please check our online Provider Directory or call Member Services at 800-537-9384 for a participating oral and maxillofacial surgeon.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.
Not covered: • *Dental implants* • *Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*	*All charges*
Organ/tissue transplants	**High**	**Basic**
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See Section 3 "*Other services* under *You need prior Plan approval for certain services."* • 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	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Basic**
• Liver • Lung: single/bilateral/lobar • Pancreas; Pancreas/Kidney (simultaneous)	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - High-risk neuroblastoma - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.
Blood or marrow stem cell transplants Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells 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 non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)* - Hemoglobinopathies - Hematopoietic Stem Cell Transplant (HSCT) - Infantile malignant osteopetrosis - Kostmann's syndrome	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Basic**
- Leukocyte adhesion deficiencies - Marrow Failure and Related Disorders(i.e. Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic Syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer* - Ependymoblastoma - Epithelial Ovarian Cancer* - Ewing's sarcoma - Hematopoietic Stem Cell Transplant (HSCT) - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors - Waldenstrom's macroglobulinemia *Approved clinical trial necessary for coverage.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Basic**
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health **approved clinical trial** or a Plan-designated center of excellence. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Allogeneic transplants for: - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Non-myeloblative 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 lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodyplastic Syndromes - Myeloproliferative disorders (MPDs) - Non-small cell lung cancer - Ovarian cancer	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Basic**
- Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle Cell anemia • Autologous Transplants for: - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/ lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma* - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive) - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Basic**
• **National Transplant Program (NTP) -** Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your primary care doctor and plan specialist physician and approved by our medical director in advance of the surgery. The transplant must be performed at hospitals (Institutes of Excellence) specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program. *Note: Transplants must be performed at hospitals designated as Institutes of Excellence (IOE). Hospitals in our network, but not designated as an IOE hospital will not be covered. 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.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.
Clinical trials must meet the following criteria: A. The member has a current diagnosis that will most likely cause death within one year or less despite therapy with currently accepted treatment; or the member has a diagnosis of cancer; AND B. *All* of the following criteria must be met: 1. Standard therapies have not been effective in treating the member or would not be medically appropriate; and 2. The risks and benefits of the experimental or investigational technology are reasonable compared to those associated with the member's medical condition and standard therapy based on at least two documents of medical and scientific evidence (as defined below); and 3. The experimental or investigational technology shows promise of being effective as demonstrated by the member's participation in a clinical trial satisfying ALL of the following criteria:	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High**	**Basic**
a. The experimental or investigational drug, device, procedure, or treatment is under current review by the FDA and has an Investigational New Drug (IND) number; and b. The clinical trial has passed review by a panel of independent medical professionals (evidenced by Aetna's review of the written clinical trial protocols from the requesting institution) approved by Aetna who treat the type of disease involved and has also been approved by an Institutional Review Board (IRB) that will oversee the investigation; and c. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national cooperative body (e.g., Department of Defense, VA Affairs) and conforms to the rigorous independent oversight criteria as defined by the NCI for the performance of clinical trials; and d. The clinical trial is not a single institution or investigator study (NCI designated Cancer Centers are exempt from this requirement); and 4. The member must: a. Not be treated "off protocol," and b. Must actually be enrolled in the trial.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.	$35 per specialist visit Nothing for the surgery. See section 5(c) for facility charges.
Not covered: • *The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials. Terminal illness means a medical prognosis of 6 months or less to live); and* • *Costs of data collection and record keeping that would not be required but for the clinical trial; and* • *Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., "protocol-induced costs"); and* • *Items and services provided by the trial sponsor without charge* • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*

Benefit Description	You pay	
Anesthesia	**High**	**Basic**
Professional services including Acupuncture - when provided as anesthesia for a covered surgery) provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note: For sedation or anesthesia relating to dental services performed in a dental office, see Section 5 (g), Dental benefits. Note: When the anesthesiologist is the primary giver of services, such as for pain management, the specialist copay applies.	Nothing	Nothing

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.
- We define observation as monitoring patients following medical or surgical treatments to determine if you need more care, need admission or can be discharged. Observation care can be billed as Emergency Room, Outpatient, or Inpatient depending on where services are rendered, benefited accordingly and how it is billed to us within the scope of the facilities contract. Hospital observation cost share is determined as anything greater than 23 hours, and Aetna's policy is to allow up to 48 hours of hospital observation without preauthorization. After 48 hours, facilities must determine if they are going to discharge or admit the patient from observation and if admitting they will be responsible to preauthorize. Once admitted, inpatient hospital member cost sharing will apply.

Benefit Description	You pay	
Inpatient hospital	**High**	**Basic**
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. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, Immunoglobulin, and prolastin • Dressings, splints, casts, and sterile tray services	$250 per day up to a maximum of $1,000 per admission	20% of our Plan allowance per admission

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High**	**Basic**
• Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	$250 per day up to a maximum of $1,000 per admission	20% of our Plan allowance per admission
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 phone and television* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High**	**Basic**
• 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.	$175 per visit	$750 per visit

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center (cont.)	**High**	**Basic**
Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Note: Preventive care services are not subject to copays listed.	$175 per visit	$750 per visit
Services not associated with a medical procedure being done the same day, such as: • Mammogram • Radiologic procedures* • Lab tests* • Sleep studies *See below for exceptions	$35 per specialist visit	$35 per specialist visit
Complex diagnostic tests limited to: • Bone density tests – diagnostic • CT scans/MRIs/PET scans • Diagnostic angiography • Genetic testing – diagnostic* • Nuclear medicine Note: These services need precertification. See Section 3 "Services requiring our prior approval". *Note: Benefits are available for specialized diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's medical condition.	$75 copay	$75 copay
Not covered: Whole blood and concentrated red blood cells not replaced by the member.	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High**	**Basic**
Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 60 day limit per calendar year when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	30% of our Plan allowance	30% of our Plan allowance
Not covered: Custodial care	*All charges*	*All charges*

Benefit Description	You pay	
Hospice care	**High**	**Basic**
Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of a Plan doctor, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less.	$5 copay	$5 copay
Ambulance	**High**	**Basic**
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm); or 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member.	Ambulance - $100 copay **Note:** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.	Ambulance - $100 copay **Note:** If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency* • *Ambulette service* • *Ambulance transportation for member convenience or reasons that are not medically necessary* Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*	*All charges*

Section 5(d). Emergency Services/Accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- We define observation as monitoring patients following medical or surgical treatments to determine if you need more care, need admission or can be discharged. Observation care can be billed as Emergency Room, Outpatient, or Inpatient depending on where services are rendered, benefited accordingly and how it is billed to us within the scope of the facilities contract. Hospital observation cost share is determined as anything greater than 23 hours, and Aetna's policy is to allow up to 48 hours of hospital observation without preauthorization. After 48 hours, facilities must determine if they are going to discharge or admit the patient from observation and if admitting they will be responsible to preauthorize. Once admitted, inpatient hospital member cost sharing will apply.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area

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

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

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

Emergencies outside our service area

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

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

Follow-up Care after Emergencies

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

Benefit Description	You pay	
Emergency within our service area	**High**	**Basic**
• Emergency or urgent care at a doctor's office	$20 per PCP visit $35 per specialist visit	$15 per PCP visit $35 per specialist visit
• Services provided at a Walk in clinic or CVS MinuteClinic®	$0 per visit	$0 per visit
• Emergency or urgent care at an urgent care center	$50 per visit	$100 per visit
• Emergency care as an outpatient at a hospital (Emergency Room), including doctors' services.	$125 per visit Note: If you are admitted from the Emergency Room to a hospital, the copay is waived.	$250 per visit Note: If you are admitted from the Emergency Room to a hospital, the copay is waived.
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High**	**Basic**
• Emergency or urgent care at a doctor's office	$35 per specialist visit	$35 per specialist visit
• Services provided at a Walk in clinic or CVS MinuteClinic®	$0 per visit	$0 per visit
• Emergency or urgent care at an urgent care center	$50 per visit	$100 per visit
• Emergency care as an outpatient at a hospital (Emergency Room), including doctors' services.	$125 Note: If you are admitted from the Emergency Room to a hospital, the copay is waived.	$250 Note: If you are admitted from the Emergency Room to a hospital, the copay is waived.
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers.* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area.* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges*	*All charges*

Benefit Description	You pay	
Telehealth services	**High**	**Basic**
• Teladoc Health consult	$35 per consult	$35 per consult
• CVS Health Virtual Care™ consult	$0 per consult	$0 per consult
Please refer to www.aetnafed.com/tools.php for information on medical and behavioral telehealth services. Members will receive a welcome kit explaining the telehealth benefits. Refer to Section 5(e) for behavioral health telehealth consults.		
Ambulance	**High**	**Basic**
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. Air or sea ambulance may be covered. Prior approval is required. Note: See 5(c) for non-emergency service.	$100 copay Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.	$100 copay Note: If you receive medically necessary air or sea ambulance transport services, you pay a copayment of $150 per day.
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency.* • *Ambulette service.* • *Air ambulance without prior approval.* • *Ambulance transportation for member convenience or for reasons not medically necessary.*	*All charges*	*All charges*

Ambulance - continued on next page

Benefit Description	You pay	
Ambulance (cont.)	**High**	**Basic**
Note: Elective air ambulance transport, including facility-to-facility transfers, requires prior approval from the Plan.	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR CERTAIN SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. Please see Section 3 of this brochure for a list of services that require preauthorization.
- Aetna can assist you in locating participating providers in the Plan, unless your needs for covered services extend beyond the capability of the affiliated providers. Emergency care is covered (See Section 5(d), Emergency services/accidents). You can receive information regarding the appropriate way to access the behavioral health care services that are covered under your specific plan by calling Member Services at 800-537-9384. A referral from your PCP is not necessary to access behavioral health care but your PCP may assist in coordinating your care.
- We will provide medical review criteria for denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay	
Professional services	**High**	**Basic**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Psychiatric office visits to Behavioral Health practitioner • Substance Use Disorder (SUD) office visits to Behavioral Health practitioner • Routine psychiatric office visits to Behavioral Health practitioner • Behavioral therapy	$35 per visit	$35 per visit
• Telehealth Behavioral Health consult	$35 per consult	$35 per consult
• CVS Health Virtual Care™ telehealth consult	$35 per consult	$35 per consult

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)	**High**	**Basic**
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.	$35 per visit	$35 per visit
Applied Behavior Analysis (ABA)	**High**	**Basic**
Applied Behavior Analysis (ABA) The plan covers medically necessary applied behavior analysis (ABA) therapy when provided by network behavioral health providers. These providers include: • Providers who are licensed or who possess a state-issued or state-sanctioned certification in ABA therapy. • Behavior analysts certified by the Behavior Analyst Certification Board (BACB). • Registered Behavior Technicians (RBTs) certified by the BACB or equivalent paraprofessionals who work under the supervision of a licensed provider or a certified behavior analyst. Note: Requires Precertification. See Section 3 “Services requiring our prior approval”. You are responsible for ensuring that we are asked to precertify your care. You should always ask your physician or hospital whether they have contacted us. For precertification or criteria subject to medical necessity, please contact us at 800-537-9384.	$35 per visit	$35 per visit
Diagnostics	**High**	**Basic**
• 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	$35 per outpatient visit	$35 per outpatient visit

Benefit Description	You pay	
Inpatient hospital or other covered facility	**High**	**Basic**
Inpatient services provided and billed by a hospital or other covered facility including an overnight residential treatment facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	$250 per day up to a maximum of $1,000 per admission	20% of our Plan allowance per admission
Outpatient hospital or other covered facility	**High**	**Basic**
Outpatient services provided and billed by a hospital or other covered facility. Other outpatient mental health treatment such as: • Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician • Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician • Outpatient detoxification • Ambulatory detoxification which is outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications • Electro-convulsive therapy (ECT) • Transcranial magnetic stimulation (TMS) • Psychological/Neuropsychological testing	$35 per outpatient visit	$35 per outpatient visit
Not covered	**High**	**Basic**
• *Educational services for treatment of behavioral disorders* • *Services in half-way houses*	*All charges*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- This is a five tier open formulary pharmacy plan, Advanced Control Formulary. The formulary is a list of drugs that your health plan covers. With your Advanced Control Formulary Pharmacy plan, each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Each tier has a separate out-of-pocket cost.
  - Preferred generic
  - Preferred brand
  - Non-preferred generic and brand
  - Preferred specialty
  - Non-preferred specialty
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorization for certain prescription drugs and supplies before coverage applies. Prior approval/authorization must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Upon approval by the Plan, the prescription is covered for the current calendar year or a specified time period, whichever is less.

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

- **Who can write your prescription.** A licensed Plan physician or dentist, and in states allowing it, licensed/ or certified providers with prescriptive authority prescribing within their scope of practice.
- **Where you can obtain them.** You must fill non-emergency prescriptions at a participating Plan retail pharmacy for up to a 30-day supply, or by mail order for a 31-day up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay, (retail pharmacy) and for a 31-day up to a 90-day supply of medication for two copays (mail order). In no event will the copay exceed the cost of the prescription drug. For retail pharmacy transactions, you must present your Aetna Member ID card at the point of sale for coverage. Please call Member Services at 800-537-9384 for more details on how to use the mail order program. **Mail order is not available for drugs and medications ordered through a network Specialty Pharmacy. Prescriptions ordered through a network Specialty Pharmacy are only filled for up to a 30-day supply due to the nature of these prescriptions.** In an emergency or urgent care situation, you may fill your covered prescription at any retail pharmacy. If you obtain your emergency prescription at a pharmacy that does not participate with the plan, you will need to pay the pharmacy the full price of the prescription and submit a claim for reimbursement subject to the terms and conditions of the plan.
- **We use an open managed formulary.** The formulary is a list of drugs that your Plan covers. Drugs are prescribed by licensed doctors and covered in accordance with the 2025 Pharmacy Drug Guide. Certain drugs require your doctor to get precertification or step therapy from the Plan before they can be covered under the Plan. Your prescription drug plan includes drugs listed in the 2025 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.com/Pharmacy to review our 2025 Pharmacy Drug (Formulary) Guide or call 800-537-9384.

- **Drugs not on the formulary.** Formularies are developed and reviewed by the CVS Caremark Pharmacy and Therapeutics Committee, comprised of physicians, pharmacists and other clinicians that review drugs for inclusion in the formulary. They consider the drug's effectiveness and safety in their evaluation. While most of the drugs on the non-formulary list are brand drugs, some generic drugs also may be on the non-formulary list. For example, this may happen when brand medications lose their patent and the FDA has granted a period of exclusivity to specific generic manufacturers. When this occurs, the price of the generic drug may not decrease as you might think most generic drugs do. This period of exclusivity usually ranges between 3-6 months. Once this time period expires, competition from other generic manufacturers will generally occur and this helps lower the price of the drug and this may lead the Plan to re-evaluate the generic for possible inclusion on the formulary. We will place some of these generic drugs that are granted a period of exclusivity on our non-formulary list, which requires the highest copay level. **Remember, a generic equivalent will be dispensed, if available, unless your physician specifically requires a brand name and writes "Dispense as Written" (DAW) on the prescription, so discuss this with your doctor.**
- **Choose generics.** The Plan requires the use of generics if a generic drug is available. If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/coinsurance* unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained. 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: 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 may be covered for up to a 30-day supply. Members **must** obtain a 31-day up to a 90-day supply of covered prescription medication through mail order. In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available, unless your physician specifically requires a brand name.

  In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filing of their medication(s) prior to departure, their pharmacist will need to contact Aetna. Coverage of additional prescriptions will only be allowed if there are refills remaining on the member's current prescription or a new prescription has been issued by their physician. The member is responsible for the applicable copayment for the additional prescription.
- The Plan allows coverage of a medication refill when at least 80% of the previous prescription, according to the physician's prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a prescription refill to be covered 24 days after the last filling, thereby allowing a member to have an additional supply of their medication, in case of emergency.
- **When you do have to file a claim.** Send your itemized bill(s) to: Aetna, P.O. Box 52444, Phoenix, AZ 85072-2444.

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

- A generic equivalent may be dispensed if it is available, and where allowed by law.
- **Mail order pharmacy.** Generally the drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. Outpatient prescription drugs are covered when dispensed by a network mail order pharmacy or a CVS pharmacy®. Each prescription is limited to a maximum 90-day supply. Prescriptions for less than a 30-day supply or more than a 90-day supply are not eligible for coverage when dispensed by a network mail order pharmacy.

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

  Certain Specialty Formulary medications identified on the Specialty Drug List may be covered under the medical or pharmacy section of this brochure depending on how and where the medication is administered. If the provider supplies and administers the medication during an office visit, you will pay the applicable PCP or specialist office visit copay. If you obtain the prescribed medications directly from a network specialty pharmacy. You will pay the applicable copay as outlined in Section 5(f) of this brochure.

  Often these drugs require special handling, storage and shipping. For a detailed listing of specialty medications visit www.AetnaFeds.com/Pharmacy or contact us at 800-537-9384 for a copy. Note that the medications and categories covered are subject to change. **Some specialty medications may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, you shall not receive credit toward your out-of-pocket maximum or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.**

- To request a printed copy of the 2025 Pharmacy Drug (Formulary) Guide, call 800-537-9384. The information in the 2025 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 at www.AetnaFeds.com/Pharmacy for current 2025 Pharmacy Drug (Formulary) Guide information.

Benefit Description	You pay	
Covered medications and supplies	**High**	**Basic**
We cover the following medications and supplies prescribed by a licensed physician or dentist and obtained from a Plan pharmacy or through our mail order program: • Drugs approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as *Not covered* • Diabetic supplies limited to - Lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips - Insulin - Disposable needles and syringes needed to inject covered prescribed medications • Prenatal vitamins (as covered under the plan's formulary) • Drugs to treat gender dysphoria • Medications prescribed to treat obesity • Oral and Injectable Infertility medications (includes Artificial Insemination (AI), In vitro fertilization (IVF)/ART medications)	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per Preferred Generic (PG) formulary drug; $35 per Preferred Brand (PB) name formulary drug; and $100 per covered Non-Preferred (NP) (generic or brand name) drug. Mail Order Pharmacy, or CVS Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 per Preferred Generic (PG) formulary drug $70 per Preferred Brand (PB) name formulary drug; and $200 per covered Non-Preferred (NP) (generic or brand name) drug.	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $5 per Preferred Generic (PG) formulary drug; $35 per Preferred Brand (PB) name formulary drug; and $100 per covered Non-Preferred (NP) (generic or brand name) drug. Mail Order Pharmacy, or CVS Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $10 per Preferred Generic (PG) formulary drug $70 per Preferred Brand (PB) name formulary drug; and $200 per covered Non-Preferred (NP) (generic or brand name) drug.

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High**	**Basic**
Note: If your physician prescribes or you request a covered brand name prescription drug when a generic prescription drug equivalent is available, you will pay the difference in cost between the brand name prescription drug and the generic prescription drug equivalent, plus the applicable copayment/ coinsurance unless your physician submits a preauthorization request providing clinical necessity and a medical exception is obtained. Note: Certain drugs to treat Gender dysphoria and infertility are considered specialty drugs. Please see Specialty drugs in this section. Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation program with a prescription. (See Section 5(a)). OTC drugs will not be covered unless you have a prescription and that prescription is presented at the pharmacy and processed through our pharmacy claim system.	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $10 per Preferred Generic (PG) formulary drug; $35 per Preferred Brand (PB) name formulary drug; and $100 per covered Non-Preferred (NP) (generic or brand name) drug. Mail Order Pharmacy, or CVS Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 per Preferred Generic (PG) formulary drug $70 per Preferred Brand (PB) name formulary drug; and $200 per covered Non-Preferred (NP) (generic or brand name) drug.	Retail Pharmacy, for up to a 30-day supply per prescription or refill: $5 per Preferred Generic (PG) formulary drug; $35 per Preferred Brand (PB) name formulary drug; and $100 per covered Non-Preferred (NP) (generic or brand name) drug. Mail Order Pharmacy, or CVS Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $10 per Preferred Generic (PG) formulary drug $70 per Preferred Brand (PB) name formulary drug; and $200 per covered Non-Preferred (NP) (generic or brand name) drug.
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site www.hrsa.gov/womens-guidelines. Contraceptive coverage is available at no cost to FEHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below. Over-the-counter and prescription drugs approved by the FDA to prevent unintended pregnancy. Visit www.AetnaFeds.com/FamilyPlanning.php for more information on contraception and the the exception process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov.	See coverage below	See coverage below

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High**	**Basic**
Reimbursement for covered over-the-counter contraceptives can be submitted in accordance with Section 7. Note: For additional Family Planning benefits see Section 5(a).	See coverage below	See coverage below
Women's contraceptive drugs and devices • Generic oral contraceptives on our formulary list • Generic injectable contraceptives on our formulary list - five (5) vials per calendar year • Generic emergency contraception, including OTC when filled with a prescription • Diaphragms - one (1) per calendar year • Brand name Intra Uterine Device • Generic patch contraception Note: If it is medically necessary for you to use a prescription drug on the Formulary Exclusions List, you or your prescriber must request a medical exception. Visit our website at www.AetnaFeds.com/Pharmacy to review our 2025 Pharmacy Drug (Formulary) Guide or call 800-537-9384.	Nothing	Nothing
• Brand name contraceptive drugs • Brand name injectable contraceptive drugs such as Depo Provera - five (5) vials per calendar year • Brand emergency contraception	Retail Pharmacy, for up to a 30 day supply per prescription or refill: $35 per Preferred Brand (PB) name formulary drug; and $100 per covered Non-Preferred (NP) (generic or brand name) drug. Mail Order Pharmacy, or CVS Pharmacy, for a 31 day up to a 90 day supply per prescription or refill: $70 per Preferred Brand (PB) name formulary drug; and $200 per covered Non-Preferred (NP) (generic or brand name) drug.	Retail Pharmacy, for up to a 30 day supply per prescription or refill: $35 per Preferred Brand (PB) name formulary drug; and $100 per covered Non-Preferred (NP) (generic or brand name) drug. Mail Order Pharmacy, or CVS Pharmacy, for a 31 day up to a 90 day supply per prescription or refill: $70 per Preferred Brand (PB) name formulary drug; and $200 per covered Non-Preferred (NP) (generic or brand name) drug.

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High**	**Basic**
Specialty Medications **Specialty medications must be filled through a network specialty pharmacy.** These medications are not available through the mail order benefit. Certain Specialty Formulary medications identified on the Specialty Drug List may be covered under the medical or pharmacy section of this brochure. Please refer to above, Specialty Drugs for more information or visit**:** www.AetnaFeds.com/Pharmacy	Up to a 30 day supply per prescription or refill: Preferred Specialty (PSP): 50% up to a $350 maximum Non-preferred Specialty (NPSP): 50% up to $700 maximum	Up to a 30 day supply per prescription or refill: Preferred Specialty (PSP): 50% up to a $350 maximum Non-preferred Specialty (NPSP): 50% up to $700 maximum
Limited benefits: • Drugs to treat erectile dysfunction are limited up to six (6) tablets per 30-day period. Contact the Plan at 800-537-9384 for dose limits.	Retail Pharmacy, for up to a 30 day supply per prescription or refill: $10 per Preferred Generic (PG) formulary drug; $35 per Preferred Brand (PB) name formulary drug; and $100 per covered Non-Preferred (NP) (generic or brand name) drug.	Retail Pharmacy, for up to a 30 day supply per prescription or refill: $5 per Preferred Generic (PG) formulary drug; $35 per Preferred Brand (PB) name formulary drug; and $100 per covered Non-Preferred (NP) (generic or brand name) drug.
Preventive care medications	**High**	**Basic**
Preventive Care medications to promote better health as recommended by ACA. Drugs and supplements are covered without cost-share which includes some over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. We will cover preventive medications in accordance with the U.S. Preventive Services Task Force (USPSTF) recommendations/guidance: • Aspirin • Folic acid supplements • Oral Fluoride • Statins • Breast Cancer Prevention drugs • HIV PrEP • Nicotine Replacement Medications (Limits apply) • Bowel Prep Medications (Required with preventive Colonoscopy)	Nothing	Nothing

Preventive care medications - continued on next page

Benefit Description	You pay	
Preventive care medications (cont.)	**High**	**Basic**
Opioid rescue agents such as naloxone are covered under this Plan with no cost sharing when obtained from an in-network pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at: https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to https://www.findtreatment.samhsa.gov/ 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. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations.	Nothing	Nothing
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available, i.e., an over-the-counter (OTC) drug unless required by law or covered by the plan.* • *Drugs obtained at a non-Plan pharmacy except when related to out-of-area emergency care* • *Vitamins, unless otherwise stated (including prescription vitamins), nutritional supplements not listed as a covered benefit, and any food item, including infant formula, medical foods and other nutritional items, even if it is the sole source of nutrition when administered under the direction of a Plan doctor (please see Durable Medical Equipment in Section 5(a) for more information on what the plan will cover).* • *Lost, stolen or damaged drugs* • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Nonprescription medications unless specifically indicated elsewhere*	*All charges*	*All charges*

Preventive care medications - continued on next page

Benefit Description	You pay	
Preventive care medications (cont.)	**High**	**Basic**
• *Prophylactic drugs including, but not limited to, anti-malarials for travel* • *Compounded bioidentical hormone replacement (BHR) therapy that includes progesterone, testosterone and/or estrogen* • *Compounded thyroid hormone therapy*	*All charges*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- You have two different dental options, Advantage Dental or Dental PPO, from which to choose. New members are automatically enrolled in the Advantage Dental option. If you want to switch to the Dental PPO option, you must call on or before the 15th of the month to have your coverage in the Dental PPO option be effective on the first of the following month (i.e., call on 1/8 and your coverage is effective on 2/1, but if you call on 1/17, your coverage will not be effective until 3/1).
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- **Under the Advantage Dental option, you must select a Plan primary care dentist before receiving care.** Your selected Plan primary care dentist must provide or arrange covered care. **Services rendered by non-Plan dentists are not covered.** The Plan will cover 100% of the charges for the preventive, diagnostic and restorative procedures shown on the next page. You will be responsible for a copayment of $5 for each office visit regardless of the number of procedures performed.

Note: You will be covered automatically under this Advantage Dental option unless you enroll in the Dental PPO option by calling Member Services at 800-537-9384.

- Under the Dental PPO option, the Plan covers 100% of the charges (after satisfaction of a $20 annual deductible per member) for those preventive, diagnostic, and restorative procedures shown on the next page when using a participating network dentist. Participating network PPO dentists may offer members other services at discounted fees. Discounts may not be available in all states. Providers are not required to honor the contracted rate/discount for dental services that are not covered or not in this section.
- You also have the choice to use non-network dentists under this Dental PPO option for those preventive, diagnostic and restorative procedures shown on the next page, but the Plan will cover only 50% of the standard negotiated rate we would have paid an in-network PPO provider. You are responsible for any difference between the amount billed and the amount paid by the Plan for the eligible services listed in this section, plus your annual $20 deductible. **Any other dental services rendered by non-network dentists are not covered.**
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described on the next pages.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
Accidental injury benefit	**High**	**Basic**
Coverage is limited to palliative treatment and those services listed on the following schedule. Note: See Oral and maxillofacial surgery, section 5(b).	See benefits below	See benefits below

Dental benefits begin on next page

Dental Benefits	You pay After the calendar year deductible...	
Service	**High**	**Basic**
Annual Deductible	No deductible	$20 per member per year.
Diagnostic	No deductible:	Nothing
Office visit for routine oral evaluation — limited to 2 visits per year	$5 per visit	
Bitewing X-rays — limited to 2 sets of bitewing X-rays per year		
Complete X-ray series — limited to 1 complete X-ray series in any 3 year period		
Periapical X-rays and other dental X-rays — as necessary		
Diagnostic casts		
Preventive		
Prophylaxis (cleaning of teeth) — limited to 2 treatments per year		
Topical application of fluoride — limited to 2 courses of treatment per year to children under age 18		
Oral hygiene instruction (not covered under PPO)		
Restorative (Fillings)		
Amalgam/Composite 1 surface, primary or permanent		
Amalgam/Composite 2 surfaces, primary or permanent		
Amalgam/Composite 3 surfaces, primary or permanent		
Amalgam/Composite 4 or more surfaces, primary or permanent		
Prosthodontics Removable		
Denture adjustments (complete or partial/upper or lower)		
Endodontics		
Pulp cap — direct		
Pulp cap — indirect		

Advantage Dental Option

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

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

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

Dental PPO

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

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

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

Dental PPO In-Network Option

The plan covers 100% of the charges (after satisfaction of the $20 annual deductible per member) for those preventive, diagnostic, and restorative procedures shown **on the previous page** when using a participating network dentist. Participating network PPO dentists may offer members other services at discounted fees. Discounts may not be available in all states. Please call Member Services at 800-537-9384 for specific fees for your procedure.

Dental PPO Non-Network Option

Dentists' normal fees generally are higher than Aetna's negotiated fees. **Non-participating dentists will be paid only for those services shown on the previous page.** Payment will be based on the standard negotiated rate provided to participating general dentists in the same geographic area. Members may be balance billed by the dentist for the difference between the dentist's usual fee and the amount paid by the Plan.

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: • Review PCP selections • Print temporary ID cards • Download details about a claim such as the amount paid and the member's responsibility • Contact member services at your convenience through secure messages • Access cost and quality information through Aetna's transparency tools • View and update your Personal Health Record • Find information about the member extras that come with your plan • Access health information through Healthwise® Knowledgebase Registration assistance is available toll free, Monday through Friday, from 7am to 9pm Eastern Time at 800-225-3375. Register today at www.AetnaFeds.com.
Services for deaf and hearing impaired	800-628-3323

Special features-continued on next page

24-Hour Nurse Line	Provides eligible members with phone access to registered nurses experienced in providing information on a variety of health topics. 24 Hour Nurse Line is available 24 hours a day, 7 days a week. You may call 24 Hour Nurse Line at 800-556-1555 . We provide TDD service for the hearing and speech-impaired. We also offer foreign language translation for non-English speaking members. 24 Hour Nurse Line nurses cannot diagnose, prescribe medication or give medical advice.
Enhanced Maternity Program	Learn about what to expect before and after delivery, early labor symptoms, newborn care and more. We can also help you make choices for a healthy pregnancy, lower your risk for early labor, cope with postpartum depression and stop smoking. We will ask you questions to help us know you better and support you best. Enroll early and receive a reward when you sign up by the 16th week of pregnancy. To enroll in the program, call toll-free 800-272-3531 between 8 am and 7 pm ET.
National Medical Excellence Program	National Medical Excellence Program helps eligible members access appropriate, covered treatment for solid organ and tissue transplants using our Institutes of Excellence™ network. We coordinate specialized treatment needed by members with certain rare or complicated conditions and assist members who are admitted to a hospital for emergency medical care when they are traveling temporarily outside of the United States. Services under this program must be preauthorized. Contact Member Services at 800-537-9384 for more information.
Reciprocity benefit	If you need to visit a participating primary care provider for a covered service, and you are 50 miles or more away from home you may visit a primary care provider from our plan's approved network. • Call 800-537-9384 for provider information and location • Select a doctor from 3 primary care providers in that area • The Plan will authorize you for one visit and any tests or X-rays ordered by that primary care provider • You must coordinate all subsequent visits through your own participating primary care provider

Non-FEHB Benefits Available to Plan Members

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

Eyewear and exams

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

Hearing aids and exams

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

Healthy lifestyle choices

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

Natural products and services

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

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

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

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

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

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

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

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

We do not cover the following:

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

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. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

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

Medical, hospital and prescription drug benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 800-537-9384 or at our website at www.AetnaFeds.com.

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

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the provider or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

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

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

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

Deadline for filing your claim

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

Post-service claims procedures

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

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

If you do not agree without initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

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

Notice Requirements

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

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

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 800-537-9384.

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

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Aetna, Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address, if you would like to receive our decision via email. Please note that by providing your email address, you may receive our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

	b) Write to you and maintain our denial; or c) Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employees Insurance Operations, FEHB 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

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

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

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

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

- **Workers' Compensation**

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

We do not cover services that:

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

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Recovery rights related to Workers' Compensation

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

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

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

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

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

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

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

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

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

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

Clinical trials

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

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan. See Section 5(b).
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs. See Section 5(b).
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs. See Section 5(b).

When you have Medicare

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

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

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

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

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

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

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

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

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

Basic Option: EXAMPLE

Benefit Description: Deductible
Basic Option You pay **without** Medicare: $0
Basic Option You pay **with** Medicare Parts A and B (primary): $0

Benefit Description: Part B Premium
Basic Option You pay **without** Medicare: NA
Basic Option You pay **with** Medicare Parts A and B (primary): No Reimbursement Offered

Benefit Description: Primary Care Provider
Basic Option You pay **without** Medicare: $15
Basic Option You pay **with** Medicare Parts A and B (primary): $15

Benefit Description: Specialist
Basic Option You pay **without** Medicare: $35 per visit
Basic Option You pay **with** Medicare Parts A and B (primary): $35 per visit

Benefit Description: Inpatient Hospital
Basic Option You pay **without** Medicare: 20% of our Plan allowance per admission
Basic Option You pay **with** Medicare Parts A and B (primary): 20% of our Plan allowance per admission

Benefit Description: Outpatient Hospital
Basic Option You pay **without** Medicare: $750 per visit
Basic Option You pay **with** Medicare Parts A and B (primary): $750 per visit

Benefit Description: Incentives offered
Basic Option You pay **without** Medicare: NA
Basic Option You pay **with** Medicare Parts A and B (primary): We offer no additional incentives when a member has Medicare Part B.

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

- **Tell us about your Medicare coverage**

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

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

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

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. For more information, please call us at 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		✓*
9) Are a Federal employee receiving disability benefits for six months or more	✓	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

Section 10. Definitions of Terms We Use in This Brochure

Assignment

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

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

Calendar year

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

Clinical Trials Cost Categories

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

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

- Routine care costs - costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan. See Section 5(b).
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. We do not cover these costs. See Section 5(b).
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs. See Section 5(b).

Coinsurance

See Section 4.

Copayment

See Section 4.

Cost-sharing

See Section 4.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Any type of care provided according to Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; or c) is a level such that you have reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Custodial care includes any type of care where the primary purpose is to attend to your daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples include assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of noninfected wounds, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by you, the general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in our sole determination, is based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, or convalescent care. Custodial care that lasts 90 days or more is sometimes known as long term care. Custodial care is not covered.

Deductible

See Section 4.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

Emergency care

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

Experimental or investigational services

Services or supplies that are, as determined by us, experimental. A drug, device, procedure or treatment will be determined to be experimental if:

- There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- Required FDA approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes.

Note: When a medical necessity determination is made utilizing the Aetna Clinical Policy Bulletins (CPBs), you may obtain a copy of the CPB through the Internet at:

www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html

Health care professional

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

Infertility

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

Medical foods

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

Medical necessity

Also known as medically necessary or medically necessary services. "Medically necessary " means that the service or supply is provided by a physician or other health care provider exercising prudent clinical judgment for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that provision of the service or supply is:

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

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

Note: When a medical necessity determination is made utilizing the Aetna Clinical Policy Bulletins (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

Open Access HMO	You can go directly to any network specialist for covered services without a referral from your primary care provider. Whether your covered services are provided by your selected primary care provider (for your PCP copay) or by another participating provider in the network (for the specialist copay), you will be responsible for payment which may be in the form of a copay (flat dollar amount) or coinsurance (a percentage of covered expenses). While not required, it is highly recommended that you still select a PCP and notify Member Services of your selection (800-537-9384). **If you go directly to a specialist, you are responsible for verifying that the specialist is participating in our Plan. If your participating specialist refers you to another provider, you are responsible for verifying that the other specialist is participating in our Plan.**
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for the service or supply in the geographic area where it is furnished. Plans determine their allowances in different ways. We determine our allowance as follows: We may take into account factors such as the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility, and the prevailing charge in other areas in determining the Plan allowance for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area. You should also see Important Notice About Surprise Billing – Know Your Rights in Section 4 that describes your protections against surprise billing under the No Surprises Act.
Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims were treatment has been performed and the claims have been sent to us in order to apply for benefits.
Pre-service claims	Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.
Precertification	Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or you. It also allows Aetna to coordinate your transition from the inpatient setting to the next level of care (discharge planning), or to register you for specialized programs like disease management, case management, or our prenatal program. In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments. Certain health care services, such as hospitalization or outpatient surgery, require precertification with Aetna to ensure coverage for those services.
Preventive care	Health care services designed for prevention and early detection of illnesses in average risk people, generally including routine physical examinations, tests and immunizations.
Referral	For Open Access members, you do not need a referral for specialist care within our network.
Reimbursement	A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.
Respite care	Care furnished during a period of time when your family or usual caretaker cannot, or will not, attend to your needs. Respite care is not covered.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Surprise bill

An unexpected bill you receive for

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

Urgent care

Covered benefits required in order to prevent serious deterioration of your health that results from an unforeseen illness or injury if you are temporarily absent from our service area and receipt of the health care service cannot be delayed until your return to our service area.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Member Services Department at 800-537-9384. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Aetna.

You

You refers to the enrollee and each covered family member.

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

Notes

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Summary of Benefits for the High Option of the Aetna Open Access Plan - 2025

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.AetnaFeds.com.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $35 specialist	34
Services provided by a hospital: Inpatient	$250 per day up to a maximum of $1,000 per admission	62
Services provided by a hospital: Outpatient	$175 per visit	63
Emergency benefits: In-area	$125 per visit	67
Emergency benefits: Out-of-area	$125 per visit	67
Mental health and substance use disorder treatment:	Regular cost-sharing	70
Prescription drugs: In no event will the copay exceed the cost of the prescription drug. • Retail pharmacy; for up to a 30-day supply per prescription unit or refill	$10 per Preferred Generic (PG) formulary drug; $35 per Preferred Brand (PB) name formulary drug; and $100 per Non-Preferred (NP) drug (generic or brand name).	75
Prescription drugs: In no event will the copay exceed the cost of the prescription drug. • Mail order pharmacy; for a 31-day to a 90-day supply per prescription unit or refill	$20 per Preferred Generic (PG) formulary drug; $70 per Preferred Brand (PB) name formulary drug; and $200 per Non-Preferred (NP) drug (generic or brand name).	75
Specialty Medications: For up to a 30-day supply per prescription unit or refill	Preferred Specialty (PSP): 50% up to a $350 maximum per prescription Non-preferred Specialty (NPSP): 50% up to $700 maximum per prescription	78
Dental care:	Various copays, coinsurance, reduced fees or deductibles	81
Vision care:	$35 copay per visit. All charges over $100 for eyeglasses or contacts per 24-month period	45
Special features: Flexible benefits option, Services for the deaf and hearing-impaired, Informed Health, Maternity Management Program, National Medical Excellence Program, and Reciprocity benefit.	Contact Plan at 800-537-9384	84

High Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $5,000/Self Only enrollment or $10,000/Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection	28

Summary of Benefits for the Basic Option of the Aetna Open Access Plan -2025

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.AetnaFeds.com.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Basic Option Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $35 specialist	34
Services provided by a hospital: Inpatient	20% of our Plan allowance per admission	62
Services provided by a hospital: Outpatient	$750 per visit	63
Emergency benefits: In-area	$250 per visit	67
Emergency benefits: Out-of-area	$250 per visit	67
Mental health and substance use disorder treatment:	Regular cost-sharing	70
Prescription drugs: In no event will the copay exceed the cost of the prescription drug. • Retail pharmacy; for up to a 30-day supply per prescription unit or refill	$5 per Preferred Generic (PG) formulary drug; $35 per Preferred Brand (PB) name formulary drug; and $100 per Non-Preferred (NP) drug (generic or brand name).	75
Prescription drugs: In no event will the copay exceed the cost of the prescription drug. • Mail order; for a 31-day to a 90-day supply per prescription unit or refill	$10 per Preferred Generic (PG) formulary drug; $70 per Preferred Brand (PB) name formulary drug; and $200 per Non-Preferred (NP) drug (generic or brand name).	75
Specialty Medications: For up to a 30-day supply per prescription unit or refill	Preferred Specialty (PSP): 50% up to a $350 maximum per prescription Non-preferred Specialty (NPSP): 50% up to a $700 maximum per prescription	78
Dental care:	Various copays, coinsurance, reduced fees or deductibles	81
Vision care:	$35 copay per visit. All charges over $200 for eyeglasses or contacts per 24-month period	45
Special features: Flexible benefits option, Services for the deaf and hearing-impaired, Informed Health, Maternity Management Program, National Medical Excellence Program, and Reciprocity benefit	Contact Plan at 800-537-9384	84

Basic Option Benefits	You Pay	Page
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $7,000/Self Only enrollment or $12,000/Self Plus One or Self and Family enrollment per year. Some costs do not count toward this protection	28

2025 Rate Information for the Aetna Open Access Plan

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

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

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

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Northern, NJ					
High Option Self Only	JR1	$298.08	$767.55	$645.84	$1,663.03
High Option Self Plus One	JR3	$650.00	$1,787.06	$1,408.33	$3,871.97
High Option Self and Family	JR2	$714.23	$1,747.21	$1,547.50	$3,785.62
Basic Option Self Only	JR4	$298.08	$564.83	$645.84	$1,223.80
Basic Option Self Plus One	JR6	$650.00	$1,330.05	$1,408.33	$2,881.78
Basic Option Self and Family	JR5	$714.23	$1,285.63	$1,547.50	$2,785.53
Delaware, Southern NJ, Philadelphia & SE Pennsylvania					
High Option Self Only	P31	$298.08	$544.91	$645.84	$1,180.64
High Option Self Plus One	P33	$650.00	$1,373.61	$1,408.33	$2,976.16
High Option Self and Family	P32	$714.23	$1,329.61	$1,547.50	$2,880.82
Basic Option Self Only	P34	$298.08	$530.31	$645.84	$1,149.01
Basic Option Self Plus One	P36	$650.00	$1,253.64	$1,408.33	$2,716.22
Basic Option Self and Family	P35	$714.23	$1,208.47	$1,547.50	$2,618.35

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
NYC & Upstate NY					
High Option Self Only	JC1	$298.08	$589.15	$645.84	$1,276.49
High Option Self Plus One	JC3	$650.00	$1,520.66	$1,408.33	$3,294.77
High Option Self and Family	JC2	$714.23	$1,478.13	$1,547.50	$3,202.61
Basic Option Self Only	JC4	$298.08	$482.29	$645.84	$1,044.96
Basic Option Self Plus One	JC6	$650.00	$1,234.66	$1,408.33	$2,675.10
Basic Option Self and Family	JC5	$714.23	$1,189.26	$1,547.50	$2,576.73