



A consumer driven individual practice plan

Serving the following states: California, Connecticut, District of Columbia, Georgia, Illinois, Indiana, Maryland, New Jersey, New York, Pennsylvania, Virginia and Washington

Underwritten and administered by: Aetna Life Insurance Company

Who may enroll in this Plan: You must live or work in our geographic service area to enroll. See pages 11 - 12 for requirements.



Enrollment codes for this Plan:

- 221 Self Only
- 222 Self and Family



Special Notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2003 Open Season.

Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>





UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our Web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the Web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James
Director

Notes



Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM will use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM has the right to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM may use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you have the right to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.

- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707.

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

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Introduction

This brochure describes the benefits you can receive of Aetna Life Insurance Company under our contract (CS 2888) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the Aetna* administrative office is:

Aetna Life Insurance Company
920B Harvest Drive
Mail Stop U40A
Blue Bell, PA 19422.

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. OPM negotiates benefits and rates with each plan annually. Benefits are effective January 1, 2004. Rates are shown at the end of this brochure.

* "Aetna" is the brand name used for products and services provided by one or more of the Aetna group subsidiary companies. Plan benefits are provided by Aetna Life Insurance Company.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or email OPM at fehbwcomments@opm.gov. You may also write to OPM at the United States Office of Personnel Management, Insurance Services Program, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) 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 you can do to prevent fraud:

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

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-888/238-6240 and explain the situation.
 - If we do not resolve the issue:

**CALL – THE HEALTH CARE FRAUD HOTLINE
202/418-3300**

**OR 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); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing Medical Mistakes

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

1. **Ask questions if you have doubts or concerns.**
 - Ask questions and make sure you understand the answers.
 - Choose a doctor with whom you feel comfortable talking.
 - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
 - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
 - Tell them about any drug allergies you have.
 - Ask about side effects and what to avoid while taking the medicine.
 - Read the label when you get your medicine, including all warnings.
 - Make sure your medicine is what the doctor ordered and know how to use it.
 - Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.**
 - Ask when and how you will get the results of tests or procedures.
 - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
 - Call your doctor and ask for your results.
 - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
 - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
 - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
 - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
 - Ask your doctor, "Who will manage my care when I am in the hospital?"
 - Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
 - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. 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 healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's healthcare delivery system.

Section 1. Facts about this consumer driven individual practice plan

This Plan is a consumer driven individual practice plan. You can choose your own physicians, hospitals, and other health care providers. You are encouraged to use a network primary care physician for your general health care needs.

We reimburse you or your provider for your covered services, usually based on a percentage of our Plan allowance. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

We have Network Providers:

Our network providers offer services through our Plan. When you use our network providers, you will receive covered services at reduced costs. In-network benefits apply only when you use a network provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. Aetna is solely responsible for the selection of network providers in your area. You can access network providers on DocFind by visiting our Web site at www.aetna.com/fehbp, or contact us for a directory or the names of network providers by calling 1-888/238-6240.

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

How we pay providers

Network Providers

Aetna negotiates with network participating providers to provide care for a discounted fee. Members are only responsible for their coinsurance based off this discounted fee.

Non-Network Providers

Because they do not participate in our networks, non-network providers are paid by Aetna a percentage of our Plan allowance for a service. Our Plan allowance is essentially a limit on fees based on what the medical care providers typically charge for a particular service in your geographic area. Members are responsible for their coinsurance portion of our Plan allowance, as well as any expense over that limit.

Your Rights

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

Medical Necessity

To be medically necessary, the service or supply must:

- Be care or treatment as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the member's overall health condition;
- Be a diagnostic procedure, indicated by the health status of the member and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the member's overall health condition;
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any equally effective service or supply in meeting the above tests.

In determining if a service or supply is medically necessary, the Plan will consider:

- Information on the member's health status;
- Reports in peer reviewed medical literature;
- Guidelines published by nationally recognized health care organizations;
- Professional standards of safety and effectiveness which are generally recognized in the United States for diagnosis, care or treatment;

- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to the Plan's attention.

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

(See definition on Page 64.)

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.

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 healthcare and maximizing coverage for those healthcare services.

Where such use is appropriate, our utilization review/patient management staff uses nationally recognized guidelines and resources, such as Milliman & Robertson Health Care Management 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.

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.

- **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 member. It also allows Aetna to coordinate the patient's transition from the inpatient setting to the next level of care (discharge planning), or to register patients 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 healthcare services, such as hospitalization or outpatient surgery, require precertification with Aetna to ensure coverage for those services. When a member is to obtain services requiring precertification through a network provider, this provider should precertify those services prior to treatment.

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

- **Concurrent Review**

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

- **Discharge Planning** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member 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 members 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 Health plan properly and efficiently. After you receive your ID card, you can call the Member Services toll-free number on the card when you need to:

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

Confidentiality

We consider personal information to be confidential and have policies and procedures in place to protect it against unlawful use and disclosure. By “personal information,” we mean information that relates to a member’s physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

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

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

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

If you want more information about us, call 1-888/238-6240, or write to Aetna Life Insurance Company, 920B Harvest Drive, Mail Stop U40A, Blue Bell, PA 19422. You may also contact us by fax at 1-215/775-5246 or visit our Web site at www.aetna.com/fehbp.

Service Area

To enroll in this Plan, you must live or work in our Service Area. This is where our network providers practice. Our Service Areas are:

California

Serving: Northern California area

Counties: Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, Santa Clara, Santa Cruz, San Mateo, Solano, and Sonoma

Serving: Central Valley area

Counties: Amador, El Dorado, Fresno, Kings, Madera, Merced, Nevada, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo, and Yuba

Serving: Southern California area

Los Angeles area

Counties: Kern, Los Angeles, Orange, Riverside, San Bernardino, San Luis Obispo, Santa Barbara, and Ventura

San Diego area

Counties: San Diego

Connecticut

Serving: All of Connecticut

District of Columbia

Serving: All of Washington, DC

Georgia

Serving: Atlanta area

Counties: Barrow, Bartow, Butts, Chattooga, Cherokee, Clarke, Clayton, Cobb, Coweta, Dawson, DeKalb, Douglas, Fayette, Floyd, Forsyth, Fulton, Gordon, Gwinnett, Hall, Haralson, Henry, Jackson, Jasper, Lamar, Madison, Newton, Oconee, Oglethorpe, Paulding, Pickens, Pike, Polk, Rockdale, Spalding, and Walton and portions of the following counties as defined by the below listed towns:

Banks: Commerce

Carroll: Bowdon, Bowdon Junction, Carrolton, Mount Zion, Roopville, Temple, Villa Rica, and Whitesburg

Illinois

Serving: Chicago area

Counties: Cook, DuPage, Kane, Kankakee, Lake, McHenry, and Will and portions of the following counties as defined by the below listed towns:

Ford: Cabery, Kempton, and Piper City

Iroquois: Ashkum, Beaverville, Chebanse, Clifton, Crescent City, Danforth, Donovan, Gilman, Iroquois, Martinton, Onarga, Papineau, Sheldon, Watseka, and Woodland

Indiana

Serving: Indiana (part of Chicago, IL network)

Counties: Lake and Porter

| | |
|---------------------|--|
| Maryland | Serving: All of Maryland |
| New Jersey | Serving: All of New Jersey |
| New York | Serving: New York City area Counties: Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster, and Westchester |
| Pennsylvania | Serving: Philadelphia and Southeastern PA area Counties: Berks, Bucks, Chester, Delaware, Monroe, Montgomery, and Philadelphia |
| Virginia | Serving: Northern/Central/Richmond, VA areas Central and Richmond, VA areas Counties: Albemarle, Amelia, Caroline, Charles City, Charlotte, Charlottesville City, Chesterfield, Colonial Heights City, Cumberland, Dinwiddie, Fluvanna, Goochland, Hanover, Henrico, Hopewell City, King George, King William, Lunenburg, Nelson, New Kent, Nottoway, Petersburg City, Powhatan, Prince Edward, Prince George, Richmond City, and Westmoreland and portions of the following county as defined by the below listed towns: Buckingham: Arvonias, Buckingham, Dillwyn, and New Canton Northern VA area (part of District of Columbia network) Counties: Arlington, Clarke, Fairfax, Fauquier, Loudon, Prince William, Spotsylvania, and Stafford; plus the cities of Alexandria, Fairfax, Falls Church, Fredericksburg, Manassas, Manassas Park, and Winchester. |
| Washington | Serving: Seattle/Western Washington area Counties: Clallam, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Snohomish, Thurston, and Whatcom |

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), 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. We are a new Plan

This Plan is new to the FEHB program. We are being offered for the first time during the 2003 Open Season.

Flexible Spending Accounts through FSAFEDS are now available to most Federal employees. You can set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20-40% on services you routinely incur and pay for out-of-pocket. See page 70.

We included information regarding Preventing Medical Mistakes. See page 6.

We included information regarding applying for Medicare. See page 57.

We revised the Medicare Primary Payer Chart. See page 59.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-888/238-6240 or request them through our Web site at www.aetna.com/fehbp.

Where you get covered care

You can get care from any licensed provider or licensed facility. How much we pay – and you pay – depends on whether you use a network or non-network provider or facility. If you use a non-network provider, you will pay more.

- **Network providers**

Network providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Network providers according to national standards.

We list Network providers in the provider directory, which we update periodically. The most current information on our Network providers is also on our Web site at www.aetna.com/fehbp under DocFind.

- **Network facilities**

Network facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these facilities in the provider directory, which we update periodically. The most current information on our Network facilities is also on our Web site at www.aetna.com/fehbp under DocFind.

- **Non-network providers and facilities**

You can access care from any licensed provider or facility. Providers and facilities not in Aetna's networks are considered non-network providers and facilities.

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance.

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and

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

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

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

- **Hospital care**

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

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

If you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 1-888/238-6240. If you are new to the FEHB Program, we will arrange for you to receive care.

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; or
- 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.

How to Get Approval for...

- **Your hospital stay**

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

NOTE: If you go to a Non-network hospital, you are responsible for precertifying your care.

Warning

If you are using a non-network physician or hospital, we will reduce our benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

- **How to precertify an admission**

Certification of days of confinement can be obtained as follows:

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

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

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

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

- **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 48 hours after a vaginal delivery or 96 hours after 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.

- **What happens when you do not follow the precertification rules when using Non-network Facilities**

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

Circumstances beyond our control

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

Services requiring our prior approval

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

You must obtain approval for certain services such as:

- For inpatient mental health and substance abuse care. You must contact Member Services at 1-888/238-6240 or call the behavioral health contractor for information on precertification;
- For surgical treatment of morbid obesity;
- For orthognathic surgery and TMJ surgery, and surgery to correct congenital defects;
- For select outpatient surgery;
- For inpatient confinements, skilled nursing facilities, rehabilitation facilities, and inpatient hospice;
- For covered transplant surgery;
- When full-time skilled nursing care is necessary in an extended care facility;
- For non-emergent ambulance and air ambulance transportation services;
- For growth hormone therapy treatment;
- For penile implants;
- For certain durable medical equipment;
- For all home health care services; and
- For home intravenous (IV) and antibiotic therapy.

Members must call Member Services at 1-888/238-6240 for authorization.

Section 4. Your costs for covered services

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

- **Copayments** There are no copayments under the Medical Fund.
- **Deductible**

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them.

After you have exhausted your Medical Fund Account, you must satisfy your deductible before your Traditional Medical Coverage begins. Your deductible is \$1,000 for a Self Only enrollment and \$2,000 for a Self and Family enrollment. The Self and Family deductible can be satisfied by one or more family members.

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

Coinsurance is the percentage of our Plan allowance that you must pay for your care after you have used up your Medical Fund Account and paid your deductible.
- **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. If your covered expenses are being paid out of your Medical Fund Account or if you are receiving in-network covered preventive services, the Plan will pay 100%. If you have exhausted your Medical Fund Account, you will be responsible for paying your deductible and also coinsurance under the Traditional Medical Coverage.
 - **Non-Network Providers:** If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount. **Note:** The amount in excess of our Plan allowance is not an eligible expense that can be paid from the Medical Fund Account.

Your catastrophic protection out-of-pocket maximum for deductibles and coinsurance

If you have exceeded your Medical Fund Account and met your deductible the following would apply:

Self Only: Your annual out-of-pocket maximum is \$5,000.

Self and Family: Your annual out-of-pocket maximum is \$10,000.

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

- Any expenses paid by the Plan under your Medical Fund Account
- Any expenses paid by the Plan under your In-network Preventive Care benefit
- Expenses in excess of our allowance or maximum benefit limitations or expenses not covered under the Traditional Medical Coverage

- Copay expenses for prescription drugs
- Any coinsurance expenses you have paid for infertility services
- Dental care expenses above the maximum limitations provided under your Dental Fund Account
- The \$500 penalty for failure to obtain precertification when using a Non-network facility and any other amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements
- Expenses in excess of hospice care maximums

Out-of-Pocket Maximums

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

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

NOTE: Once you have exhausted your Medical Fund Account, paid your deductible, and satisfied your out-of-pocket maximums, eligible medical expenses will be covered at 100%.

Section 5. Benefits — OVERVIEW

(See page 76 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-888/238-6240.

The Aetna HealthFund Plan focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. With this Plan, in-network preventive care is covered in full up to a maximum of \$300 per member, and you can use the Medical Fund for any covered care. If you use up your Medical Fund, the Traditional Medical Coverage begins after you satisfy your deductible. If you don't use up your Medical Fund for the year, you can roll it over to the next year, up to the maximum rollover amount, as long as you continue to be enrolled in the Aetna HealthFund Plan.

The Aetna HealthFund Plan includes three key components:

5.1 In-network Preventive Care22

This component covers 100% for preventive care for adults and children if you use a network provider up to \$300 per member per year. The covered services include office visits/exams, immunizations and screenings and are fully described in Section 5.1. They are based on recommendations by the American Medical Association and the American Academy of Pediatrics.

5.2 Aetna HealthFund (Medical and Dental Funds).....24

The Plan also provides a Medical Fund for each enrollment. Each year, the Plan provides \$1,000 for a Self Only enrollment or \$2,000 for a Self and Family enrollment. The Medical Fund covers 100% of your eligible medical expenses.

If you have an unused Medical Fund balance at the end of the calendar year, you will rollover that balance so you can use it in the future, up to the maximum rollover amount, as long as you continue to participate in the Medical Fund. If you terminate your participation in the Plan, your Medical Fund balance is lost. The Medical Fund is described in Section 5.2.

NOTE: In-network Preventive Care benefits paid under Section 5.1 do NOT count against your Medical Fund Account.

The Plan also provides a Dental Fund for each enrollment. Each year, the Plan provides \$300 for a Self Only enrollment or \$600 for a Self and Family enrollment.

The Dental Fund covers 100% of your eligible dental expenses. You cannot rollover any unused Dental Fund balance at the end of the calendar year. The Dental Fund is described in Section 5.2.

5.3 Traditional Medical Coverage (Subject to the Deductible)28

After you have used up your Medical Fund and paid your deductible (\$1,000 for Self Only enrollment or \$2,000 for a Self and Family enrollment), the Plan starts paying benefits under the Traditional Medical Coverage described in Section 5.3. The Plan generally pays 85% of the cost for in-network care and 60% of our Plan allowance for out-of-network care for the following:

- (a) Medical services and supplies provided by physicians and other health care professionals29
- (b) Surgical and anesthesia services provided by physicians and other health care professionals.....37
- (c) Services provided by a hospital or other facility, and ambulance services41
- (d) Emergency services/accidents.....44
- (e) Mental health and substance abuse benefits46
- (f) Prescription drug benefits.....47

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| (g) Health tools and resources..... | 50 |
| (h) Non-FEHB benefits available to Plan members..... | 51 |
| Summary of benefits..... | 76 |

Section 5.1. In-network preventive care

Here are some important things to keep in mind about these in-network preventive care benefits:

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- The Plan pays 100% for the preventive care services listed in this Section as long as you use a network provider.
- For preventive care not listed in this Section or preventive care from a non-network provider, please see Section 5.2 – Medical Fund.
- For all other covered expenses, please see section 5.2 – Medical Fund and Section 5.3 – Traditional Medical Coverage.
- Note that the in-network preventive care paid under this Section does NOT count against or use up your Medical Fund up to the \$300 limit. Covered preventive care over the \$300 per member annual limit can be paid under the Medical Fund, if available, or Traditional Medical coverage after your deductible has been satisfied.
- 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.

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| Benefit Description | You Pay |
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| Preventive care, adult | |
| <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Total Blood Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test every 12 months – Sigmoidoscopy screening — every five years starting at age 50 – Double contrast barium enema — every five years starting at age 50 – Colonoscopy screening — every 10 years starting at age 50 • Routine Prostate Specific Antigen (PSA) test — one annually for men age 40 and older • Routine annual digital rectal exam (DRE) for men age 40 and older • Routine Pap test <p>Routine mammogram — covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years <p>Routine physicals</p> <ul style="list-style-type: none"> • One exam every 24 months up to age 65 • One exam every 12 months age 65 and older | <p>In-network: Nothing at a network provider, up to a \$300 annual maximum per member, plus your available Medical Fund balance. Charges above the available Medical Fund balance, according to the Traditional Medical Coverage (Section 5.3) and the deductible.</p> <p>Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above the available Medical Fund balance, according to the Traditional Medical Coverage (Section 5.3) and the deductible.</p> |

Preventive care, adult – Continued on the next page

| Preventive care, adult (<i>continued</i>) | You Pay |
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| <p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster — once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over • 1 routine eye exam every 12 months • 1 routine OB/GYN exam every 12 months including 1 pap smear and related services • 1 routine hearing exam every 24 months | <p>In-network: Nothing at a network provider, up to a \$300 annual maximum per member, plus your available Medical Fund balance. Charges above the available Medical Fund balance, according to the Traditional Medical Coverage (Section 5.3) and the deductible.</p> <p>Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above the available Medical Fund balance, according to the Traditional Medical Coverage (Section 5.3) and the deductible.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> | <p><i>All charges.</i></p> |
| Preventive care, children | |
| <ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child visits for routine examinations, immunizations and care (up to age 22) <ul style="list-style-type: none"> – 6 exams in the first 12 months of life – 2 exams in the 13-24th months of life – 1 exam every 12 months thereafter up to age 18 – 1 exam every 24 months for children age 18 and older • 1 routine eye exam every 12 months • 1 routine hearing exam every 24 months | <p>In-network: Nothing at a network provider, up to a \$300 annual maximum per member, plus your available Medical Fund balance. Charges above the available Medical Fund balance, according to the Traditional Medical Coverage (Section 5.3) and the deductible.</p> <p>Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above the available Medical Fund balance, according to the Traditional Medical Coverage (Section 5.3) and the deductible.</p> |

Section 5.2. Medical and Dental Funds

Here are some important things to keep in mind about your Medical and Dental Funds:

Medical Fund

- All eligible health care expenses in Section 5.3 (except in-network preventive care) are paid first from your Medical Fund. Traditional Medical Coverage (subject to the deductible) (Section 5.3) will only start once your Medical Fund and deductible are exhausted.
- Note that in-network preventive care covered under Section 5.1 does NOT count against your Medical Fund unless it is in excess of the \$300 annual limit.
- The Medical Fund provides full coverage for eligible expenses from both in-network and non-network providers. However, your Medical Fund will generally go much further when you use network providers because network providers agree to discount their fees.
- You have flexibility about how to spend your Medical Fund, and the Plan provides you with the resources to manage your Medical Fund. You can track your Medical Fund on Aetna's Navigator Web site, by telephone at 1-888/238-6240 (toll-free), or with monthly statements mailed directly to you at home.
- If you join this Plan during Open Season, you receive the full Medical Fund (\$1,000 per Self Only or \$2,000 per Self and Family enrollment) as of your effective date of coverage. If you join at any other time during the year, your Medical Fund for your first year will be prorated at a rate of \$83 per month for Self Only or \$167 per month for Self and Family for each full month of coverage remaining in that calendar year. If your enrollment effective date falls between the first and fifteenth day of the month, you will be given credit as of the first of the month. If your enrollment effective date is the sixteenth or later in the month, you will be given credit as of the first of the following month.
- If you terminate your participation in this Plan, any Medical Fund balance you may have will be lost.
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY FOR NON-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.
- 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.

Dental Fund

- When you join this Plan during Open Season, on your effective date of coverage, you will have access to the entire Dental Fund (\$300 for Self Only or \$600 for Self and Family to share between you and your enrolled family members).
- Participating network PPO dentists offer members services at a negotiated rate— so, you are generally charged less for your dental care when you visit a participating network PPO dentist. Refer to our DocFind[®] online provider directory at www.aetna.com/fehbp to find a participating network PPO dentist, or call Member Services at 1-888/238-6240.

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Medical and Dental Funds – Continued on the next page

Section 5.2. Medical and Dental Funds *(continued)*

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Dental Fund *(continued)*

- All eligible dental expenses will be paid from your Dental Fund. You can track your Dental Fund on Aetna's Navigator Web site or by telephone at 1-888/238-6240.
NOTE: Once your fund is exhausted, you will continue to save on the cost of your dental care with access to the negotiated rates offered by participating network PPO dentists.
- You can visit any licensed dentist for covered services under the Dental Fund. However, you can make your Dental Fund go further by taking advantage of the negotiated rates offered by a participating network PPO dentist. These negotiated rates are generally less than the dentist's usual fees.
- **REMEMBER:** If you terminate your participation in this Plan, any Dental Fund balance you may have will be lost.
- Any unused, remaining balance in your Dental Fund at the end of your calendar year will *not* rollover, regardless of whether you stay in the Plan or not.
- 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.

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| Benefit Description | You Pay | | | | | | |
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| Medical Fund | | | | | | | |
| <p>A Medical Fund Account is provided by the Plan for each enrollment. Each year the Plan adds to your account:</p> <ul style="list-style-type: none"> • \$1,000 per year for a Self Only enrollment, or; • \$2,000 per year for a Self and Family enrollment. <p>The Medical Fund covers eligible expenses at 100%. For example, if you are ill and go to a network doctor for a \$60 visit, the doctor will submit your claim and the cost of the visit will be deducted automatically from your Medical Fund; you pay nothing.</p> <table style="margin-left: 40px;"> <tr> <td>Balance in Medical Fund for Self Only</td> <td style="text-align: right;">\$ 1,000</td> </tr> <tr> <td>Less: Cost of visit</td> <td style="text-align: right;"><u> 60</u></td> </tr> <tr> <td>Remaining Balance in Medical Fund</td> <td style="text-align: right;">\$ 940</td> </tr> </table> | Balance in Medical Fund for Self Only | \$ 1,000 | Less: Cost of visit | <u> 60</u> | Remaining Balance in Medical Fund | \$ 940 | <p>Nothing for eligible expenses until you exhaust your Medical Fund.</p> |
| Balance in Medical Fund for Self Only | \$ 1,000 | | | | | | |
| Less: Cost of visit | <u> 60</u> | | | | | | |
| Remaining Balance in Medical Fund | \$ 940 | | | | | | |
| <ul style="list-style-type: none"> • Medical Fund expenses are the same medical, surgical, hospital, emergency, mental health and substance abuse, and prescription drug services and supplies covered under the Traditional Medical Coverage (see Section 5.3 for details). <p>To make the most of your Medical Fund, you should:</p> <ul style="list-style-type: none"> • Use the network providers whenever possible; and • Use generic prescriptions whenever possible | <p>Nothing for eligible expenses until you exhaust your Medical Fund.</p> | | | | | | |

Medical Fund – Continued on the next page

| Medical Fund (continued) | You Pay | | | | | | |
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| <p>Medical Fund Rollover</p> <p>Provided you remain enrolled in the Aetna HealthFund, any unused, remaining balance in your Medical Fund at the end of the calendar year may be rolled over to subsequent years.</p> <p>NOTE: This rollover feature can increase your Medical Fund in the following year(s) up to a maximum rollover of \$4,000 for Self Only or \$8,000 for a Self and Family enrollment.</p> | | | | | | | |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses and contact lenses (see the non-FEHB page for our Vision One Program)</i> • <i>Non-network preventive care services not included under Section 5(a)</i> • <i>Services or supplies shown as not covered under Traditional Medical Coverage (see Section 5(c))</i> • <i>Charges of non-network providers that exceed our Plan allowance.</i> | <p><i>All charges.</i></p> | | | | | | |
| <p>Dental Fund</p> <p>Dental Fund expenses include dental services up to a maximum of \$300 for Self Only or \$600 for Self and Family enrollment.</p> <p>The Dental Fund covers eligible expenses at 100%. For example, if you go to a network dentist for a \$125 visit, the doctor will submit your claim and the cost of the visit will be deducted automatically from your Dental Fund; you pay nothing.</p> <table border="0" style="margin-left: 40px;"> <tr> <td>Balance in Dental Fund for Self Only</td> <td style="text-align: right;">\$ 300</td> </tr> <tr> <td>Less: Cost of visit</td> <td style="text-align: right;"><u>– 125</u></td> </tr> <tr> <td>Remaining Balance in Dental Fund</td> <td style="text-align: right;">\$ 175</td> </tr> </table> <p>NOTE: Any unused remaining balance in your Dental Fund at the end of the calendar year <i>cannot</i> be rolled over to the next year.</p> <p>Eligible dental covered services include:</p> <p><u>Diagnostic and Preventive Care</u></p> <ul style="list-style-type: none"> • Prophylaxis (two per calendar year) • Bitewing (one set per calendar year) and full mouth series X-rays (one set every 3 years) • Space maintainers (primary teeth only) • Oral exams (two per calendar year) • Fluoride applications (one treatment per calendar year for children under age 16) • Sealants (Once every 3 years, from the last date of service, on permanent molars for children under age 16) | Balance in Dental Fund for Self Only | \$ 300 | Less: Cost of visit | <u>– 125</u> | Remaining Balance in Dental Fund | \$ 175 | <p>Nothing for eligible expenses until you exhaust your Dental Fund.</p> <p>NOTE: Once your Dental Fund is exhausted, you pay the negotiated rates offered by participating network PPO dentists, and all costs at non-network dentists.</p> |
| Balance in Dental Fund for Self Only | \$ 300 | | | | | | |
| Less: Cost of visit | <u>– 125</u> | | | | | | |
| Remaining Balance in Dental Fund | \$ 175 | | | | | | |

Dental Fund – Continued on the next page

| Dental Fund (<i>continued</i>) | You Pay |
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| <p><u>Basic Restorative Care</u></p> <ul style="list-style-type: none"> • Periapical X-rays • Fillings • Simple extractions • Oral surgery • Endodontics • Periodontics | |
| <p><u>Major Restorative Care</u></p> <ul style="list-style-type: none"> • Inlays/onlays • Crowns • Bridgework • Osseous surgery (one per quadrant every 3 years, from the last date of service) • Partial and full bony impactions • General anesthesia and intravenous sedation • Dentures (benefit includes all relines, rebases and adjustments within 6 months of installation) • Molar root canal therapy • Prosthetic repairs • Occlusal guards (for bruxism only) – one every 3 years, from the last date of service | <p>Nothing for eligible expenses until you exhaust your Dental Fund.</p> <p>NOTE: Once your Dental Fund is exhausted, you pay the negotiated rates offered by participating network PPO dentists, and all costs at non-network dentists.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthodontia</i> • <i>Dental treatment for cosmetic purposes</i> • <i>Dental care involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> • <i>Dental implants</i> • <i>Dentures, bridges or crowns if installed less than 8 years prior to repairs or replacement</i> • <i>Charges of non-network providers that exceed our Plan allowance</i> | <p><i>All charges.</i></p> |

Section 5.3. Traditional Medical Coverage (Subject to the Deductible)

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Here are some important things to remember 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.
- In-network preventive care is covered at 100% under Section 5.1 and does not count against your Medical Fund (up to \$300 per member per year).
- Your Medical Fund **must** be used first for eligible health care expenses.
- Once your Medical Fund has been exhausted, you must pay your deductible before your Traditional Medical Coverage may begin.
- The Medical Fund provides coverage for both network and non-network providers. Under the Traditional Medical Coverage, in-network benefits apply only when you use a network provider. Out-of-network benefits apply when you do not use a network provider.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY FOR NON-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

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| Benefit Description | You pay |
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| Deductible before Traditional Medical Coverage begins | |
| <p>Once your Medical Fund Account has been exhausted, you must satisfy your deductible before your Traditional Medical Coverage begins.</p> <p>Traditional Medical Coverage benefits begin after you have satisfied your deductible of \$1,000 for Self Only and \$2,000 for Self and Family each calendar year. The Self and Family deductible can be satisfied by one or more family members.</p> <p>NOTE: You must use any available Medical Fund amounts, including any amounts rolled over from previous years, before Traditional Medical Coverage begins.</p> <p>Once your Traditional Medical Coverage begins, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.</p> | <p>\$1,000 per Self Only enrollment or \$2,000 per Self and Family enrollment</p> |

Traditional Medical Coverage

Section 5.3(a). Medical services and supplies provided by physicians and other health care professionals

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Here are some important things to keep in mind about these benefits:

- The deductible is \$1,000 for Self Only and \$2,000 for Self and Family each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in Section 5.3.
- After you have exhausted your Medical Fund and satisfied your deductible, your Traditional Medical Coverage begins.
- Under your Traditional Medical Coverage, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions.
- 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.

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| Benefit Description | You pay |
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| Diagnostic and treatment services | |
| Professional services of physicians <ul style="list-style-type: none"> • In physician’s office <ul style="list-style-type: none"> – Office medical consultations – Second surgical or medical opinion – Initial examination of a newborn child covered under a family enrollment • In an urgent care center for a routine service • During a hospital stay • In a skilled nursing facility | In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. |
| <ul style="list-style-type: none"> • At home | In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. |

| Lab, X-ray and other diagnostic tests | You pay |
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| <p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CT Scans/MRI • Ultrasound • Electrocardiogram and EEG | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| Maternity care | |
| <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>NOTE: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits and Surgery benefits. | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p> | <p><i>All charges.</i></p> |

| Family Planning | You pay |
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| <p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms <p>NOTE: We cover oral contraceptives and Depo Provera under the prescription drug benefit.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered: Reversal of voluntary surgical sterilization, genetic counseling</i></p> | <p><i>All charges.</i></p> |
| Infertility services | |
| <p>Infertility is defined as the inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination) for women under age 35 and 6 months of unprotected intravaginal sexual relations (or 6 cycles of artificial insemination) for women age 35 and over.</p> <ul style="list-style-type: none"> • Artificial insemination <ul style="list-style-type: none"> – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intrauterine insemination (IUI) • Testing for diagnosis and surgical treatment of the underlying cause of infertility. • Fertility drugs except injectables <p>NOTE: We cover oral fertility drugs under the prescription drug benefit.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>In vitro fertilization</i> – <i>Embryo transfer including, but not limited to, gamete GIFT and zygote ZIFT</i> – <i>Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services.</i> – <i>Services and supplies related to the above mentioned services, including sperm processing</i> • <i>Reversal of voluntary, surgically-induced sterility.</i> • <i>Treatment for infertility when the cause of the infertility was a previous sterilization.</i> • <i>Injectable fertility drugs</i> • <i>Infertility treatment when the FSH level is greater than 19 mIU/ml.</i> • <i>The purchase, freezing and storage of donor sperm and donor embryos.</i> | <p><i>All charges.</i></p> |

| Allergy care | You pay |
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| <p>Testing and treatment</p> <p>Allergy injection</p> <p>Allergy serum</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p> | <p><i>All charges.</i></p> |
| Treatment therapies | |
| <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>NOTE: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 39.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy — Home IV and antibiotic therapy must be precertified by your attending physician. • Growth hormone therapy (GHT) <p>NOTE: We will only cover GHT when we preauthorize the treatment. Call 1-800/245-1206 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and it is authorized by Aetna. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| Physical and occupational therapies | |
| <ul style="list-style-type: none"> • 20 visits per condition per member per calendar year, beginning with the first day of treatment for the services of each of the following: <ul style="list-style-type: none"> – Qualified physical therapists – Occupational therapists <p>NOTE: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>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 rehabilitation is covered under Hospital/Extended Care Benefits.</p> <ul style="list-style-type: none"> • Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |

Physical and occupational therapies – Continued on the next page

| Physical and occupational therapies (<i>continued</i>) | You pay |
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| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> | <p><i>All charges.</i></p> |
| Pulmonary and cardiac rehabilitation | |
| <ul style="list-style-type: none"> • 20 visits per condition per member per calendar year for pulmonary rehabilitation to treat functional pulmonary disability. • Cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or a myocardial infarction is provided for up to 3 visits a week for a total of 18 visits. | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> | <p><i>All charges.</i></p> |
| Speech therapy | |
| <ul style="list-style-type: none"> • 20 visits per condition per member per calendar year, beginning with the first day of treatment | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| Hearing services (testing, treatment and supplies) | |
| <ul style="list-style-type: none"> • One hearing exam every 24 months | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing aids, testing and examinations for them</i> | <p><i>All charges.</i></p> |

| Vision services (testing, treatment and supplies) | You pay |
|---|---|
| <ul style="list-style-type: none"> • Treatment of eye diseases and injury • One routine eye refraction every 12-month period | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Corrective eyeglasses and frames or contact lenses (also see the non-FEHB page for our Vision One Program)</i> • <i>Fitting of contact lenses</i> • <i>Eye exercises</i> • <i>Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors</i> | <p><i>All charges.</i></p> |
| Foot care | |
| <p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See <i>Orthopedic and prosthetic devices</i> for more information.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open manipulation or fixation)</i> • <i>Foot orthotics</i> • <i>Podiatric shoe inserts</i> | <p><i>All charges.</i></p> |
| Orthopedic and prosthetic devices | |
| <ul style="list-style-type: none"> • Orthopedic devices such as braces and prosthetic devices such as artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy, and lenses following cataract removal. See Surgical section for coverage of the surgery to insert the device. | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |

Orthopedic and prosthetic devices – Continued on the next page

| Orthopedic and prosthetic devices (<i>continued</i>) | You pay |
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| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes not attached to a covered brace</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Penile implants</i> | <p><i>All charges.</i></p> |
| Durable medical equipment (DME) | |
| <p>Rental or purchase, including replacement, repair and adjustment, of durable medical equipment prescribed by your attending Physician such as oxygen equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds (Clinitron and electric beds must be preauthorized); • Wheelchairs (motorized wheelchairs and scooters must be preauthorized); • Crutches; • Walkers; and • Insulin pumps. <p>NOTE: Some DME may require precertification by you or your physician.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elastic stockings and support hose</i> • <i>Bathroom equipment such as bathtub seats, benches, rails and lifts</i> • <i>Home modifications such as stairglides, elevators and wheelchair ramps</i> | <p><i>All charges.</i></p> |
| Home health services | |
| <ul style="list-style-type: none"> • Home health care ordered by an attending Physician and provided by nurses and home health aides. Your attending Physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications. <p>NOTE: Home health services must be precertified by your attending Physician.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |

Home health services – Continued on the next page

| Home health services (continued) | You pay |
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| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family.</i> • <i>Transportation</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Services of a social worker</i> | <p><i>All charges.</i></p> |
| Chiropractic | |
| <p><i>No benefit</i></p> | <p><i>All charges.</i></p> |
| Alternative treatments | |
| <p><i>No benefit</i></p> | <p><i>All charges.</i></p> |
| Educational classes and programs | |
| <ul style="list-style-type: none"> • Congestive heart failure <p>Also see the Non-FEHB page for our Fitness Program.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |

Section 5.3(b). Surgical and anesthesia services provided by physicians and other health care professionals

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Here are some important things to keep in mind about these benefits:

- There is a deductible of \$1,000 for Self Only and \$2,000 for Self & Family.
- 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.
- YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY FOR NON-NETWORK FACILITY CARE. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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| Benefit Description | You pay |
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| Surgical procedures | |
| <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. This procedure must be approved in advance by Aetna. • Insertion of internal prosthetic devices. See — <i>Orthopedic and prosthetic devices</i> for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgically-induced sterilization</i> • <i>Surgery primarily for cosmetic purposes</i> • <i>Radial keratotomy, and laser eye surgery, including related procedures designed to surgically correct refractive errors</i> • <i>Whole blood and concentrated red blood cells not replaced by the member</i> • <i>Routine treatment or conditions of the foot; see Foot Care</i> | <p><i>All charges.</i></p> |

| Reconstructive surgery | You pay |
|--|---|
| <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – The condition produced a major effect on the member’s appearance and – The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – Surgery to produce a symmetrical appearance of breasts; – Treatment of any physical complications, such as lymphedemas; – Breast prostheses and surgical bras and replacements (see Orthopedic and prosthetic devices) <p>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.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> | <p><i>All charges.</i></p> |
| Oral and maxillofacial surgery | |
| <p>Oral surgical procedures, such as:</p> <ul style="list-style-type: none"> • Treatment of fractures of the jaws or facial bones; • Surgical correction of congenital defects, such as cleft lip and cleft palate, must be preauthorized; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Removal of bony impacted wisdom teeth; • Excision of tumors and cysts • Other surgical procedures that do not involve the teeth or their supporting structures. | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Dental implants</i> • <i>Dental care involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> | <p><i>All charges.</i></p> |

| Organ/tissue transplants | You pay |
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| <p>National Transplant Program (NTP) - Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your attending doctor and plan specialist and approved by our medical director in advance of the surgery. To receive in-network benefits, the transplant must be performed at hospitals (Institutes of Excellence) specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor until discharge from the hospitalization when the donation occurred, to the extent these services are not covered by another plan or program.</p> <p>Transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: Single – Double • Pancreas; Pancreas/Kidney (Simultaneous) • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas • Skin • Tissue • Allogeneic (donor) bone marrow/peripheral stem cell transplants • Autologous bone marrow/peripheral stem cell transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Autologous tandem transplants for ovarian cancers, as well as for testicular cancers <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, epithelial ovarian cancer and other selected diseases may be provided in a National Cancer Institute (NCI)- or National Institutes of Health (NIH)-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |

Organ/tissue transplants – Continued on the next page

| Organ/tissue transplants (continued) | You pay |
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| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transplants not listed as covered</i> • <i>Implants of artificial organs</i> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> | <p><i>All charges.</i></p> |
| Anesthesia | |
| <p>Professional services provided in —</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office <p>NOTE: If your network provider uses a non-network anesthesiologist, we will pay out-of-network benefits for any anesthesia charges.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |

Section 5.3(c). Services provided by a hospital or other facility, and ambulance services

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Here are some important things to remember about these benefits:

- There is a deductible of \$1,000 for Self Only and \$2,000 for Self & Family.
- 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.
- YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY FOR NON-NETWORK FACILITY CARE. Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

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| Benefit Description | You pay |
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| Inpatient hospital | |
| Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary you pay the additional charge above the semiprivate room rate.</p> | In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. |
| Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, Immunoglobulin, and prolastin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home | In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. |

Inpatient hospital – Continued on the next page

| Inpatient hospital (continued) | You pay |
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| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Whole blood and concentrated red blood cells not replaced by the member</i> • <i>Non covered facilities such as nursing homes, schools</i> • <i>Custodial care, rest cures, domiciliary or convalescent cares</i> • <i>Personal comfort items, such as telephone and television</i> • <i>Private nursing care</i> | <p><i>All charges.</i></p> |
| Outpatient hospital or ambulatory surgical center | |
| <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Radiologic procedures, diagnostic laboratory tests, and X-rays when associated with a medical procedure being done the same day • Pathology Services • Administration of blood, blood plasma, and other biologicals • Blood products, derivatives and components, artificial blood products and biological serum • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>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.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Whole blood and concentrated red blood cells not replaced by the member.</i> | <p><i>All charges.</i></p> |
| Extended care benefits/skilled nursing care facility benefits | |
| <p>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.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> | <p><i>All charges.</i></p> |

| Hospice care | You pay |
|--|---|
| <p>Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of your attending Physician, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less. We allow up to a maximum of \$5,000 for outpatient hospice services and a period not to exceed 30 days for inpatient hospice services.</p> <p>Note: Inpatient hospice services require prior approval.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| Ambulance | |
| <ul style="list-style-type: none"> Local professional ambulance service when medically appropriate. | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Ambulance services for routine transportation to receive outpatient or inpatient services.</i> | <p><i>All charges.</i></p> |

Section 5.3(d). Emergency services/accidents

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Here are some important things to keep in mind about these benefits:

- There is a deductible of \$1,000 for Self Only and \$2,000 for Self & Family.
- 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.

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What is a medical emergency?

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

What to do in case of emergency:

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

| Benefit Description | You pay |
|---|---------------------------|
| <ul style="list-style-type: none"> • Emergency care as an outpatient in a hospital <p>NOTE: We pay hospital benefits if you are admitted.</p> | 15% of our Plan allowance |
| <ul style="list-style-type: none"> • Non emergency use of the Emergency Room | 50% of our Plan allowance |

Emergency services/accidents – Continued on the next page

| Ambulance | You pay |
|---|---|
| <p>Professional ambulance service when medically appropriate. Air ambulance may be covered. Prior approval is required.</p> <p>See Hospital section for nonemergency service.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Air ambulance without prior approval</i> | <p><i>All charges.</i></p> |

Section 5.3(e). Mental health and substance abuse benefits

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When you get our approval for certain services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- There is a deductible of \$1,000 for Self Only and \$2,000 for Self & Family.
- 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 INPATIENT SERVICES.**

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| Benefit Description | You pay |
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| <p>Outpatient services include:</p> <ul style="list-style-type: none"> • Individual and group therapy performed by licensed providers such as psychiatrists, psychologists, or clinical social workers • Facility based intensive outpatient or partial hospital treatment programs • Outpatient services provided by a hospital or other facility • Diagnostic tests • Medication management | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |
| <p>Inpatient care includes:</p> <ul style="list-style-type: none"> • Both mental health and chemical dependency services provided by an appropriately licensed inpatient facility including licensed residential treatment facilities <p>NOTE: All inpatient services are subject to precertification.</p> <p>NOTE: 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.</p> | <p>In-network: 15% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p> |

Network limitation

We may limit your benefits if you do not obtain a treatment plan for inpatient care.

Section 5.3(f). Prescription Drug Benefits

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Here are some important things to keep in mind about these benefits:

- There is a deductible of \$1,000 for Self Only and \$2,000 for Self & Family.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Your Medical Fund **must** be used first for eligible pharmacy expenses and your deductible must be satisfied before your Traditional Medical Coverage begins.
- **NOTE:** The cost of your prescriptions will be deducted from your Medical Fund at the time of the purchase. The cost of your prescription is based on the Aetna contracted rate with network pharmacies. The Aetna contracted rate with the network pharmacy does not reflect or include any rebates Aetna receives from drug manufacturers.
- All eligible prescription drug expenses are first deducted from your Medical Fund. Traditional Medical Coverage will only start once your Medical Fund and deductible are exhausted.
- 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.
- Certain drugs require your doctor to get precertification from the Plan before they can be prescribed under the Plan. Upon approval by the Plan, the prescription is good for the current calendar year or a specified time period, whichever is less.

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Here are some important things to remember about these benefits:

- Your Medical Fund must be used first for eligible pharmacy expenses.
- Once your Medical Fund has been exhausted, you must pay your deductible before your Traditional Medical Coverage may begin. After your Medical Fund is exhausted and your deductible is satisfied, you will pay a copayment for prescriptions under your Traditional Medical Coverage.

There are important features you should be aware which include:

- **Who can write your prescription?** A licensed physician, dentist or licensed practitioner (as allowed by law) must write the prescription.
- **Where you can obtain them.** Any retail pharmacy can be used for up to a 30-day supply. Our mail-order facility can be utilized for a 31-day up to a 90-day supply of medication (if authorized by your physician). Please call Member Services at 1-888/238-0240 for more details on how to use the mail order program. If accessing a nonparticipating pharmacy, the member must pay the full cost of the medication at the point of service, then submit a complete paper claim and a receipt for the cost of the prescription to our Direct Member Reimbursement (DMR) unit. Reimbursements are subject to review to determine if the claim meets applicable requirements, and are subject to the terms and conditions of the benefit plan and applicable law.
- **We use a formulary.** Drugs are prescribed by attending doctors and covered in accordance with the Plan's drug formulary; however, coverage is not limited to medications included on the formulary. Many non-formulary drugs are also covered but a higher copayment will apply. Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Visit our Web site at www.aetna.com/fehbp to review our Formulary Guide or call 1-888/238-0240.

- **Precertification.** We require precertification of growth hormones for all members. Precertification helps promote the appropriate and cost-effective use of growth hormones by providing coverage when certain generally accepted medical criteria are met, such as growth hormone deficiency, Turner's Syndrome and AIDS wasting. Our precertification program is based on current medical findings, manufacturer labeling information, Food and Drug Administration (FDA) guidelines and cost and manufacturer rebate arrangements.
- **When to use a participating retail or mail order pharmacy.** Covered prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy may be dispensed for up to a 30-day supply. Members must obtain a 31-day up to a 90-day supply of covered prescription medication through mail order. In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available, unless your physician specifically requires a brand name. Drug costs are calculated based on Aetna's contract rate with the pharmacy excluding any drug rebates.

In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filling of their medication(s) prior to departure, their pharmacist will need to contact Aetna. Coverage of additional prescriptions will only be allowed if there are refills remaining on the member's current prescription or a new prescription has been issued by their physician. The member is responsible for the applicable copayment for the additional prescription.

Aetna allows coverage of a medication filling when at least 75% 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 new prescription to be covered on the 23rd day, thereby allowing a member to have an additional supply of their medication, in case of emergency.

- **Why use generic drugs?** 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, when available, most members see cost savings, without jeopardizing clinical outcome or compromising quality.
- **When you have to file a claim.** Send your itemized bill(s) to: Aetna Health, Pharmacy Management, Claim Processing, P.O. Box 398106, Minneapolis, MN 55439-8106.

| Benefit Description | You pay |
|---|---|
| Covered medications and supplies | |
| <p>We cover the following medications and supplies prescribed by your attending physician or dentist and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs for which a prescription is required by Federal law, except those listed as <i>Not Covered</i> • Self-injectable drugs • Contraceptive drugs and devices • Oral fertility drugs • Diabetic supplies limited to lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips | <p>Retail Pharmacy, for up to a 30-day supply per prescription or refill:</p> <p>\$10 per covered generic formulary drug;</p> <p>\$25 per covered brand name formulary drug; and</p> <p>\$40 per covered non-formulary (generic or brand name) drug.</p> <p>Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill:</p> <p>\$20 per covered generic formulary drug</p> <p>\$50 per covered brand name formulary drug; and</p> <p>\$80 per covered non-formulary (generic or brand name) drug.</p> |

Covered medications and supplies – Continued on the next page

| Covered medications and supplies (<i>continued</i>) | You pay |
|---|---|
| <p>Limited benefits</p> <ul style="list-style-type: none"> • Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits • Imitrex (limited to 48 kits per calendar year) • Depo Provera is limited to 5 vials per calendar year • One diaphragm per calendar year | <p>50%</p> <p>\$25/kit</p> <p>\$25 copay per vial</p> <p>\$25 per diaphragm</p> |
| <p>Here are some things to keep in mind about our prescription drug program:</p> <ul style="list-style-type: none"> • A generic equivalent may be dispensed if it is available, and where allowed by law. • To request a copy of the Aetna Health Medication Formulary Guide, call 1-888/238-6240. The information in the Medication 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 Web site at www.aetna.com/fehbp for current Medication Formulary Guide information. | |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs used for the purpose of weight reduction (e.g., appetite suppressants)</i> • <i>Drugs for cosmetic purposes (e.g., Rogaine)</i> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug)</i> • <i>Lost, stolen or damaged drugs</i> • <i>Vitamins and nutritional substances that can be purchased without prescription.</i> • <i>Smoking-cessation drugs and medication including, but not limited to, nicotine patches and sprays</i> • <i>Prophylactic drugs including, but not limited to, anti-malarials for travel</i> | <p><i>All charges.</i></p> |

Section 5.3(g). Health Tools and Resources

| Special features | Description |
|---|--|
| Aetna IntelliHealthSM | <p>InteliHealth.com offers comprehensive health information that is interactive and easy-to-use. Harvard Medical School and the University of Pennsylvania School of Dental Medicine help IntelliHealth to provide trusted and credible health information to its users. Aetna IntelliHealth features include: a Drug Resource Center, Disease and Condition Management tools, the Harvard Symptom Scout (an interactive symptom checker that provides guidance about a variety of symptoms), Daily Health News and much more. Visit IntelliHealth at www.aetna.com/fehbp.</p> |
| Aetna NavigatorTM | <p>Aetna Navigator is Aetna’s member and consumer self-service Web site that provides a single source for online benefits and health-related information. As an enrolled Aetna Plan member, you can register for a secure, personalized view of your Aetna benefits through this site.</p> <p>Once registered, you can: review eligibility, view claim status and Explanation of Benefits (EOB) statements, look up and change provider selections, request member ID cards, receive personalized health and benefits messages, and contact Aetna Member Services at your convenience by sending a secure message.</p> <p>Registration assistance is available toll free, Monday through Friday, from 7 a.m. to 9 p.m. Eastern Time at 1-800/225-3375. Register today at www.aetna.com/fehbp.</p> |
| Informed Health[®] Line | <p>Provides eligible members with telephone access to registered nurses experienced in providing information on a variety of health topics. Informed Health Line is available 24 hours a day, 7 days a week. You may call Informed Health Line at 1-800/556-1555. Through Informed Health Line, members also have 24-hour access to an audio health library – equipped with information on more than 2,000 health topics, and accessible on demand through any touch tone telephone. Topics are available in both English and Spanish. We provide TDD service for the hearing and speech-impaired. We also offer foreign language translation for non-English speaking members. Informed Health Line nurses cannot diagnose, prescribe medication or give medical advice.</p> |
| Services for the deaf and hearing-impaired | 1-800/325-4591 |

Section 5.3(h). Non-FEHB benefits available to Plan members

The benefits and programs 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.

Vision One^{®1}

You are eligible to receive substantial discounts on eyeglasses, contact lenses, Lasik — the laser vision corrective procedure, and nonprescription items including sunglasses and eyewear products through the Vision One Program at more than 4,000 locations across the country.

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

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

Fitness Program

Aetna offers members access to discounted fitness services provided by GlobalFit.[™] Programs offer Plan participants:

- Low or discounted membership rates at independent health clubs contracted with GlobalFit
- Discounts on certain home exercise equipment

To determine which program is offered in your area and to view a list of included clubs, visit the GlobalFit Web site at www.globalfit.com/fitness. If you would like to speak with a GlobalFit representative, you can call the GlobalFit Health Club Help Line at 1-800/298-7800.

Natural Alternatives

The Natural Alternatives program offers reduced rates on alternative therapies including visits to acupuncturists, chiropractors, massage therapists, and nutritional counselors. Natural Alternatives is not considered insurance and the services received through the Natural Alternatives program are not part of the health benefits plan. Therefore, there is no need to precertify services before taking advantage of a Natural Alternatives reduced rate. Members can use the services of a Natural Alternatives provider at any time (subject to provider availability) and take advantage of the reduction in rate each time.

¹ Vision One is a registered trademark of Cole Vision.

Section 6. General exclusions — things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services requiring our prior approval* on page 17.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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;
- Procedures, services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; and
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

Medical, hospital, prescription drug and dental benefits

To obtain claim forms or other claims filing advice or answers about your benefits, contact us at 1-888/238-6240.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-888/238-6240.

When you must file a claim, such as when you use non-network providers, for services you receive overseas or when another group health plan is primary, submit it on the Aetna claim form. You can obtain this form by either calling us at 1-888/238-6240 or by logging onto your personalized home page on Aetna Navigator from the www.aetna.com/fehbp Web site and clicking on "Forms." Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee
- Plan identification number of the enrollee
- Name, address and taxpayer identification number of person or firm providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Type of each service or supply; and
- The charge for each service or supply

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

In addition:

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

Records

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

Deadline for filing your claim

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

Overseas claims

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

Aetna Life Insurance Company
1425 Union Meeting Road
P.O. Box 1125
Blue Bell, PA 19422.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies — including a request for preauthorization:

| Step | Description |
|------|-------------|
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| 1 | <p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: Aetna Life Insurance Company, 1425 Union Meeting Road, P.O. Box 1125, Blue Bell, PA 19422; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| 2 | <p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial — go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3. |
| 3 | <p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p> |
| 4 | <p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E St. NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">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; andYour daytime phone number and the best time to call. <p>NOTE: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> |

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.

NOTE: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

- 5** OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue 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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-888/238-6240 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 1-202/606-0755 between 8 a.m. and 5 p.m. eastern time.

External Review

If this Plan denied your claim for payment or services, you can ask us to reconsider your claim. If we still deny your claim, you can seek an independent external review, before asking OPM to review it, if:

1. The amount of your claim or service is more than \$500; and
2. The Plan denied your claim because it did not consider the treatment medically necessary or considered it experimental or investigational.

The independent external review will use a neutral, independent physician with related expertise to conduct the review. The Plan will cover the professional fee for the review and you will pay the cost to compile and send your submission to the Plan.

To request an External Review Form call 1-888/238-6240 within 60 days after receiving the Plan's written notification that it will uphold its original decision to deny your claim.

The external reviewer will make a decision within 30 days after you send us all the necessary information with the External Review Request Form. Your primary care doctor can request an expedited review in cases of "clinical urgency" where your health would be seriously jeopardized if you waited the full 30 days. In this case, the external review organization or physician will make a decision within 72 hours.

To request a detailed description of the external review requirements, call the Plan's Member Relations Office at 1-888/238-6240.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have 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 payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800/MEDICARE for information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

- **Should I enroll in Medicare?** The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800/772-1213 to set up an appointment to apply. If you do not apply for one or both Parts of Medicare, you can still be covered under the FEHB Program.

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

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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

- **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 it 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. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

Claims process when you have the Original Medicare Plan — You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-888/238-6240.

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

[Primary payer chart begins on next page.]

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer 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.

| Primary Payer Chart | | |
|--|--|---|
| A. When you — or your covered spouse — are age 65 or over and have Medicare and you... | The primary payer for the individual with Medicare is ... | |
| | Medicare | This Plan |
| 1) Are an active employee with the Federal government 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 | ✓ | ✓ |
| 2) Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant • You have FEHB coverage through your spouse who is an active employee | ✓ | ✓ |
| 3) 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) | ✓* | |
| 4) 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 | ✓ | ✓ |
| 5) 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) | ✓* | |
| 6) Are enrolled in Part B only, regardless of your employment status | ✓ for Part B services | ✓ for other services |
| 7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty | ✓** | |
| 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 payer before eligibility due to ESRD • Medicare was the primary payer before eligibility due to ESRD | ✓ | ✓ for 30-month coordination period |
| C. When either you or your spouse are eligible for Medicare solely due to disability and you... | | |
| 1) Are an active employee with the Federal government 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 | ✓ | ✓ |
| 2) You are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant • You have FEHB coverage through your spouse who is an active employee | ✓ | ✓ |
| D. When you are covered under the FEHB Spouse Equity provision as a former spouse | ✓ | |

* Unless you have FEHB coverage through your spouse who is an active employee

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

- **Medicare + Choice**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare + Choice plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare + Choice plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare + Choice plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare + Choice plan, contact Medicare at 1-800/MEDICARE (1-800/633-4227) or at www.medicare.gov.

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

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

Suspended FEHB coverage to enroll in a Medicare + Choice plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare + Choice plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare + Choice 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 + Choice plan's service area.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illnesses caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

The words "Third Party" or "Any party making payments on the third party's behalf" includes not only the insurance carrier(s) for the responsible party, but also any uninsured motorists coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage or any other first party insurance coverage. The words "Member," "you," and "your," include anyone on whose behalf the Plan pays or provides any benefits.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

You specifically acknowledge our right of subrogation. When we provide health care benefits for injuries or illnesses for which a third party is or may be responsible, we shall be subrogated to your rights of recovery against any third party to the extent of the full cost of all benefits provided by us, to the fullest extent permitted by law. We may proceed against any third party with or without your consent.

You also specifically acknowledge our right of reimbursement. This right of reimbursement attaches, to the fullest extent permitted by law, when we have provided health care benefits for injuries or illnesses for which a third party is or may be responsible and you and/or your representative has recovered any amounts from the third party or any party making payments on the third party's behalf. By providing any benefit under this Plan, we are granted an assignment of the proceeds of any settlement, judgment or other payment received by you to the extent of the full cost of all benefits provided by us. Our right of reimbursement is cumulative with and not exclusive of our subrogation right and we may choose to exercise either or both rights of recovery.

You and your representatives further agree to:

- Notify us in writing within 30 days of when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illnesses sustained by you that may be the legal responsibility of a third party; and
- Cooperate with us and do whatever is necessary to secure our rights of subrogation and/or reimbursement under this Plan; and
- Give us a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits provided by us associated with injuries or illnesses for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and
- Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due us as reimbursement for the full cost of all benefits provided by us associated with injuries or illnesses for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by us in writing; and
- Do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by us.

We may recover the full cost of all benefits provided by us under this Plan without regard to any claim of fault on the part of you, whether by comparative negligence or otherwise. We may recover the full cost of all benefits provided by us under this Plan even if such payment will result in a recovery to you which is insufficient to make you whole or fully compensate you for your damages. No court costs or attorney fees may be deducted from our recovery without the prior express written consent of us. In the event you or your representative fails to cooperate with us, you shall be responsible for all benefits paid by us in addition to costs and attorney's fees incurred by us in obtaining repayment.

Section 10. Definitions of terms we use in this brochure

| | |
|-----------------------------|--|
| Calendar year | January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year. |
| Coinsurance | Coinsurance is the percentage of our allowance that you must pay for your care. See page 18. |
| Consumer driven plan | A network provider plan under the FEHB that offers you greater control over choices of your health care expenditures. You decide what health care services will be reimbursed under the health plan funded Medical Fund Account. Unused funds from the Medical Fund will roll over at the end of the year. If you spend the entire Medical Fund before the end of the year, then you must satisfy your deductible before benefits are payable under the traditional type of insurance covered by your Plan. You decide whether to use network or non-network providers to reach the maximum amount allowed under your Medical Fund. |
| Copayment | A copayment is a fixed amount of money you pay when you receive covered services. See page 18. |
| 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 non-infected wounds; post-operative or chronic conditions; preparation of special diets; supervision of medication which can be self-administered by you; the general maintenance care of colostomy or ileostomy; routine services to maintain other service which, in our sole determination, is based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service; residential care and adult day care; protective and supportive care including educational services, rest cures, or convalescent care. Custodial care that lasts 90 days or more is sometimes known as long term care. Custodial care is not covered. |
| Deductible | A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. |

Dental Fund Account

Your Dental Fund Account is an established benefit amount which is available for you to use to pay for covered dental expenses. You determine how your Dental Fund will be spent and any unused amount at the end of the year will **not** be rolled over in subsequent year(s).

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.

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.

Medical necessity

Also known as medically necessary or medically necessary services. Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in this document. Medical Necessity, when used in relation to services, shall have the same meaning as Medically Necessary Services. This definition applies only to the determination by us of whether health care services are covered benefits under this Plan.

Medical Fund Account

Your Medical Fund Account is an established benefit amount which is available for you to use first to pay for covered hospital, medical, and pharmacy expenses. You determine how your Medical Fund will be spent and any unused amount at the end of the year may be rolled over to increase your available Medical Fund in the subsequent year(s).

Plan Allowance

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

- Network providers in our networks 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. If your covered expenses are being paid out of your Medical Fund Account, or if you are receiving in-network covered preventive services, the Plan will pay 100%. If you have exhausted your Medical Fund Account, you will be responsible for paying your deductible and also coinsurance under the Traditional Medical Coverage.
- Non-Network Providers: If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount only if you use up your Medical Fund Account for the year. Note that it usually makes sense to use network providers because it will make your Medical Fund Account go much further since money left in your Medical Fund Account can be rolled over to be used in the next year.

Respite care

Care furnished during a period of time when your family or usual caretaker cannot, or will not, attend to your needs. Respite care is not covered.

Rollover

Any unused, remaining balance in your Medical Fund at the end of the calendar year may be rolled over to subsequent years, thereby increasing your Medical Fund in the following year(s). You must use any available Medical Fund benefits, including any amounts rolled over from previous years, before Traditional Medical Coverage begins.

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.

Us/we

Us and we refer to Aetna Life Insurance Company.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

Coverage Information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family 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 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 and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

Children's Equity Act

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

If this law applies to you, you must enroll for Self 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 and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family 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 and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a Plan that doesn't serve the area in which your children live as long as the court administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on 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 2004 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2003 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.

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.

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under 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 RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary continuation of coverage (TCC)**

If you leave Federal service, 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 job, if you are a covered dependent child and you turn 22 or marry, et

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

- Your coverage under TCC or the spouse equity law ends. (If you canceled your coverage or did not pay your premium, you cannot convert);
- 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 service, your employing office will notify you of your right to convert. You must apply in writing to us 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 apply in writing to us 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, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB Web site (www.opm.gov/insure/health); refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Two new Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you know about two new Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20 to more than 40 percent on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** covers long term care costs not covered under the FEHB Program.

The Federal Flexible Spending Account Program - *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!!*

There are two types of FSAs offered by the FSAFEDS Program:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have Self and Family health benefits coverage. **Note:** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is \$3,000 annually. The minimum amount is \$250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250 annually. **Note:** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive

- **Enroll during Open Season**

- You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!
 - Enroll online anytime during Open Season (November 10 through December 8, 2003) at www.fsafeds.com.

- Call the toll-free number 1-877/FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and will be responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the “use-it-or-lose-it” rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

The **FSAFEDS Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSa pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 18 and detailed throughout this brochure. Your HCFSa will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that are NOT covered by this FEHB Plan or any other coverage that you have.

Under this Plan, typical out-of-pocket expenses include copayments for pharmacy, inpatient/outpatient hospitalization, and infertility. Expenses not covered by the Plan include chiropractic care, in-vitro fertilization, and alternative treatments such as acupuncture and hypnotherapy.

The IRS governs expenses reimbursable by a HCFSAs. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877/FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower so your tax liability will also be lower. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

| Annual Tax Savings Example | With FSA | Without FSA |
|--|-----------------|--------------------|
| If your taxable income is: | \$50,000 | \$50,000 |
| And you deposit this amount into an FSA: | \$2,000 | - \$0 - |
| Your taxable income is now: | \$48,000 | \$50,000 |
| Subtract Federal & Social Security taxes: | \$13,807 | \$14,383 |
| If you spend after-tax dollars for expenses: | - \$0 - | \$2,000 |
| Your real spendable income is: | \$34,193 | \$33,617 |
| Your tax savings: | \$576 | - \$0 - |

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), as well as your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSAs or DCFSAs. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSAs is tax-free from the first dollar. In addition, you may be reimbursed from the HCFSAs at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal income tax return.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

Probably not. While there is an administrative fee of \$4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com Web site or call 1-877/FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS Web site** at www.fsafeds.com, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877/FSAFEDS (372-3337)
- TTY: 1-800/952-0450 (for hearing-impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.

- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

Call 1-800/LTC-FEDS (1-800/582-3337) (TTY 1-800/843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for Aetna HealthFund — 2004

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Your health charges are applied to your Medical Fund, \$1,000 per Self Only and \$2,000 per Self and Family. Once your Medical Fund Account has been exhausted, you must satisfy your deductible. You pay any difference between our allowance and the billed amount if you use a non-network physician or other health care professional. Once your deductible has been satisfied, traditional medical coverage will become available.

| Benefits | You Pay | Page |
|---|--|------|
| In-network preventive care | Nothing up to \$300 per member per year | 22 |
| Medical Fund Account | Nothing up to \$1,000 for Self Only or \$2,000 for Self and Family | 24 |
| <ul style="list-style-type: none"> • Up to \$1,000 for Self Only or \$2,000 for Self and Family for medical, surgical, hospital, mental health and substance abuse services and prescription drugs. | | |
| Dental Fund Account..... | Nothing up to \$300 for Self Only or \$600 for Self and Family | 24 |
| <ul style="list-style-type: none"> • Up to \$300 for Self Only or \$600 for Self and Family for dental services. | | |
| Traditional Medical Coverage after Medical Fund Account is exhausted and after the deductible has been satisfied Medical/Surgical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office..... Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient..... | In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. | 29 |
| Emergency benefits | In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. | 44 |
| Mental health and substance abuse treatment..... | In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount. | 46 |

Summary of benefits – Continued on the next page

Summary of benefits for Aetna HealthFund — 2004 (continued)

| Benefits | You Pay | Page |
|---|--|-------------|
| Prescription drugs: After Medical Fund has been exhausted and your deductible has been satisfied, your copay will apply. <ul style="list-style-type: none"> • Plan pharmacy • Mail order | For up to a 30-day supply: \$10 per generic formulary; \$25 per brand name formulary; and \$40 per nonformulary (generic or brand name) For a 31-day up to a 90-day supply: Two copays | 47 |
| Health Tools and Resources: Services for the deaf and hearing-impaired, Informed Health Line, Aetna IntelliHealth, and Aetna Navigator | Contact Plan | 50 |
| Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) | Up to \$5,000 for Self Only or \$10,000 Self and Family. Some costs do not count toward this protection. | 18 |

Notes

Notes

2004 Rate Information for Aetna HealthFund

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

| Type of Enrollment | Code | Non-Postal Premium | | | | Postal Premium | |
|--------------------|------|--------------------|------------|-------------|------------|----------------|------------|
| | | Biweekly | | Monthly | | Biweekly | |
| | | Gov't Share | Your Share | Gov't Share | Your Share | USPS Share | Your Share |

| | | | | | | | |
|-----------------|-----|----------|---------|----------|----------|----------|---------|
| Self Only | 221 | \$97.08 | \$32.36 | \$210.34 | \$70.11 | \$114.88 | \$14.56 |
| Self and Family | 222 | \$223.30 | \$74.43 | \$483.81 | \$161.27 | \$264.24 | \$33.49 |