

Aetna HealthFund®

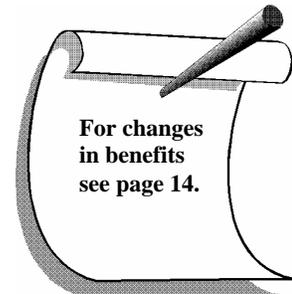
<http://www.aetna.com/fed>



2005

An individual practice plan with a consumer driven health plan option and a high deductible health plan option

Serving the following states: Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia and Washington



Underwritten and administered by: Aetna Life Insurance Company

Enrollment in this Plan is limited: You must live or work in our geographic service area to enroll. See pages 11 - 13 for requirements.



Enrollment codes for this Plan:

- 221 Consumer Driven Health Plan (CDHP) Option – Self Only**
- 222 Consumer Driven Health Plan (CDHP) Option – Self and Family**
- 224 High Deductible Health Plan (HDHP) Option – Self Only**
- 225 High Deductible Health Plan (HDHP) Option – Self and Family**

Special notice: This Plan is offering a High Deductible Health Plan (HDHP) option for the first time under the Federal Employees Health Benefits Program during the 2004 Open Season.

Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-828



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

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

Kay Coles James
Director



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 health care 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 202-606-0745 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 United States 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 2900) 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. You do not have a right to CDHP benefits that were available before January 1, 2005, unless those CDHP benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefits are effective January 1, 2005, and CDHP changes are summarized on page 14. 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 fehwebcomments@opm.gov. You may also write to OPM at the United States Office of Personnel Management, Insurance Services Programs, 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 1-800/537-9384 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 health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/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 health care 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 health care delivery system.

Section 1. Facts about the Consumer Driven Health Plan (CDHP) and High Deductible Health Plan (HDHP)

This Plan is an individual practice plan offering you a choice of a consumer driven health plan (CDHP) or a high deductible health plan (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component.

Our CDHP is a comprehensive consumer driven health plan that combines a traditional health plan with separate medical and dental funds that help you pay for covered medical and dental expenses. Aetna's CDHP puts you first, can save you time and money, and gives you flexibility, choice and control.

For 2005, CDHP offers lower out-of-pocket maximums and 100% in-network preventive care coverage, including dental. You have:

- A consumer-controlled Fund to help you pay for eligible expenses
- Opportunity to use your Fund toward medical expenses in future years
- Online tools to help you manage your money and your health
- Freedom to choose the providers you wish to see – with no referrals
- A cap that limits the total amount you pay annually for eligible expenses

CDHP delivers the best of both worlds by blending traditional health coverage with a unique Fund benefit to help you pay for covered expenses.

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

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

The type and extent of covered services, and the amount we allow, may be different from other plans. Read our brochure carefully to understand the benefits and features of this HDHP. Internal Revenue Service (IRS) rules govern the administration of all HDHPs. The IRS Website at <http://www.ustreas.gov/offices/public-affairs/hsa/faq1.html> has additional information about HDHPs.

General features of an HDHP:

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

You are eligible for a Health Savings Account (HSA) if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term care coverage), not enrolled in Medicare, have not received VA benefits within the previous three months, and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense. Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP. You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may

contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.

- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

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

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

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, are limited to \$4,000 for Self Only enrollment, or \$8,000 for Self and Family enrollment.

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/fed, or contact us for a directory or the names of network providers by calling 1-800/537-9384.

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; and
- 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 and guidelines published by nationally recognized health 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.

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

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

(See definition on Page 104)

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 health care and maximizing coverage for those health care services.

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

- **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 health care 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 participating provider, this provider should precertify those services prior to treatment.

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

- **Concurrent Review**

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

- **Discharge Planning** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by 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 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 1-800/537-9384, or write to 920B Harvest Drive, Mail Stop U40A, Blue Bell, PA 19422. You may also contact us by fax at 215/775-5246 or visit our Web site at www.aetna.com/fed.

Service Area

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

Alabama (part of Memphis, TN network) – Lamar and Pickens counties.

Alaska, Anchorage and Fairbanks – Aleutians East, Aleutians West, Anchorage, Bethel, Bristol Bay, Denali, Dillingham, Juneau, Kenai Peninsula, Ketchikan Gateway, Kodiak Island, Lake and Peninsula, Matanuska Susitna, Nome, North Slope, Skagway Yakutat Angoon, Southeast Fairbanks, Valdez Cordova and Yukon Koyukuk.

Arizona, Phoenix & Tucson – Apache, Cochise, Coconino, Gila, Graham, Greenlee, La Paz, Maricopa, Mohave, Navajo, Pima, Pinal, Santa Cruz, Yavapai, and Yuma counties.

Arkansas (part of Memphis, TN network) – Crittenden, Cross, Lee, Mississippi, Phillips and St. Francis counties.

California, Northern California – Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, Santa Clara, Santa Cruz, San Mateo, Solano, and Sonoma counties.

California, Central Valley – Amador, El Dorado, Fresno, Kings, Madera, Merced, Nevada, Placer, Sacramento, San Joaquin, Stanislaus, Sutter, Tulare, Tuolumne, Yolo, and Yuba counties.

California, Los Angeles – Kern, Los Angeles, Orange, Riverside, San Bernardino, San Luis Obispo, Santa Barbara, and Ventura counties.

California, San Diego – San Diego county.

Colorado, Denver – Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Mesa, Pueblo, Teller and Weld counties.

Connecticut – All of Connecticut.

Delaware – All of Delaware.

District of Columbia – All of Washington, DC

Florida, Jacksonville – Baker, Clay, Duval, Flagler, Nassau and St. Johns counties.

Florida, Miami – Broward and Miami-Dade counties.

Florida, Orlando – Lake, Orange, Osceola, Seminole and Sumter counties.

Florida, Tampa – Charlotte, Hillsborough, Manatee, Pasco, Pinellas, Polk and Sarasota counties.

Georgia, Atlanta – Banks, Barrow, Bartow, Butts, Carroll, 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.

Illinois, Chicago – Cook, DuPage, Ford, Grundy, Iroquois, Kane, Kankakee, Kendall, Lake, McHenry, and Will counties.

Illinois (part of St. Louis, MO network) – Alexander, Bond, Calhoun, Clinton, Fayette, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph and St. Clair counties.

Indiana (part of Chicago, IL network) – Lake and Porter counties.

Indiana (part of Cincinnati, OH network) – Dearborn, Franklin, Ohio and Switzerland counties.

Kansas, Kansas City – Allen, Anderson, Atchison, Douglas, Franklin, Johnson, Leavenworth, Miami and Wyandotte counties.

Kansas (part of Northeast OK network) – Chautauqua and Montgomery counties.

Kentucky (part of Central OH network) – Lewis county.

Kentucky (part of Cincinnati, OH network) – Boone, Boyd, Campbell, Carter, Gallatin, Grant, Greenup, Kenton, Lawrence, Mason and Pendleton counties.

Kentucky (part of Memphis, TN network) – Fulton county.

Maryland – All of Maryland

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

Michigan, Detroit– Livingston, Macomb, Monroe, Oakland, Washtenaw and Wayne counties.

Mississippi (part of Memphis, TN network) –Alcorn, Benton, Bolivar, Calhoun, Chickasaw, Coahoma, De Soto, Grenada, Itawamba, Lafayette, Lee, Lowndes, Marshall, Monroe, Panola, Pontotoc, Prentiss, Quitman, Tate, Tippah, Tunica and Union counties.

Missouri, Kansas City – Buchanan, Cass, Clay, Clinton, Henry, Jackson, Lafayette, Platte and Ray counties.

Missouri, St. Louis – Crawford, Franklin, Jefferson, Lincoln, St. Charles, St. Francois, St. Louis, St. Louis City, Ste. Genevieve and Warren counties.

Nevada, Las Vegas – Clark and Nye counties.

New Hampshire (part of Northeast New England network) – Belknap, Carroll, Cheshire, Coos, Hillsborough, Merrimack, Rockingham and Strafford counties.

New Jersey – All of New Jersey

New York, New York City – Bronx, Dutchess, Kings, Nassau, New York, Orange, Putnam, Queens, Richmond, Rockland, Suffolk, Sullivan, Ulster and Westchester counties.

New York, Upstate New York – Albany, Broome, Cayuga, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Livingston, Madison, Monroe, Montgomery, Oneida, Onondaga, Ontario, Orleans, Oswego, Rensselaer, Saratoga, Schenectady, Schuyler, Seneca, Steuben, Tioga, Tompkins, Warren, Washington, Wayne and Yates counties.

North Carolina, Charlotte and Central North Carolina – Anson, Cabarrus, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Rutherford, Stanly and Union counties.

North Carolina, Raleigh/Durham – Alamance, Bladen, Caswell, Chatham, Cumberland, Durham, Franklin, Granville, Greene, Harnett, Johnston, Lee, Lenoir, Nash, Orange, Person, Robeson, Sampson and Wake counties.

Ohio, Cincinnati – Adams, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Greene, Hamilton, Highland, Logan, Miami, Montgomery, Preble, Shelby and Warren counties.

Ohio, Cleveland – Ashland, Ashtabula, Carroll, Columbiana, Cuyahoga, Geauga, Harrison, Holmes, Jefferson, Lake, Lorain, Mahoning, Medina, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas and Wayne counties.

Ohio, Columbus and Central Ohio – Adams, Athens, Belmont, Coshocton, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Ross, Scioto, Union, Vinton and Washington counties.

Ohio, Toledo – Allen, Auglaize, Crawford, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Van Wert, Williams, Wood and Wyandot counties.

Oklahoma, Oklahoma City and Tulsa – Adair, Atoka, Beaver, Beckham, Blaine, Bryan, Caddo, Canadian, Carter, Cherokee, Choctaw, Cimarron, Cleveland, Coal, Comanche, Craig, Creek, Delaware, Dewey, Ellis, Garfield, Garvin, Grady, Grant, Greer, Harper, Haskell, Jackson, Johnston, Kay, Kingfisher, Kiowa, Latimer, Le Flore, Lincoln, Logan, Major, McClain, Mayes, Muskogee, Noble, Nowata, Oklahoma, Okmulgee, Osage, Ottawa, Pawnee, Payne, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, Roger Mills, Rogers, Seminole, Tulsa, Wagoner, Washington, Washita and Woods counties.

Pennsylvania, Philadelphia and Southeastern PA– Berks, Bucks, Chester, Delaware, Monroe, Montgomery, and Philadelphia counties.

Pennsylvania, Pittsburgh – Allegheny, Armstrong, Beaver, Blair, Butler, Cambria, Clarion, Erie, Fayette, Greene, Indiana, Jefferson, Lawrence, Mercer, Somerset, Washington, and Westmoreland counties.

South Carolina (part of Central NC network) – York county.

Tennessee, Memphis – Carroll, Dyer, Fayette, Gibson, Lake, Lauderdale, Obion, Shelby, Tipton and Weakley counties.

Tennessee, Nashville – Bedford, Cannon, Cheatham, Coffee, Davidson, DeKalb, Dickson, Franklin, Giles, Lawrence, Lewis, Lincoln, Macon, Maury, Montgomery, Moore, Robertson, Rutherford, Smith, Sumner, Trousdale, Williamson and Wilson counties.

Texas, Austin – Bastrop, Bell, Blanco, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson counties.

Texas, Dallas – Camp, Cherokee, Collin, Cooke, Dallas, Delta, Denton, Ellis, Erath, Fannin, Franklin, Freestone, Grayson, Gregg, Harrison, Henderson, Hill, Hood, Hopkins, Hunt, Johnson, Kaufman, Lamar, Marion, Montague, Morris, Navarro, Palo Pinto, Parker, Rains, Red River, Rockwall, Smith, Somervell, Tarrant, Titus, Upshur, Van Zandt, Wise and Wood counties.

Texas, Houston – Austin, Brazoria, Chambers, Colorado, Fort Bend, Galveston, Grimes, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, San Jacinto, Tyler, Walker, Waller and Wharton counties.

Texas, San Antonio – Atascosa, Bandera, Bexar, Comal, De Witt, Guadalupe, Kendall, Lavaca, Medina and Wilson counties.

Virginia, Central/Richmond, VA – Albemarle, Amelia, Buckingham, Caroline, Charles City, Charlotte, Charlottesville City, Chesterfield, Colonial Heights City, Culpeper, 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 counties.

Virginia, Northern VA area (part of District of Columbia network) – Arlington, Clarke, Fairfax, Fauquier, Loudon, Prince William, Spotsylvania, and Stafford counties; plus the cities of Alexandria, Fairfax, Falls Church, Fredericksburg, Manassas, Manassas Park, and Winchester.

Washington, Seattle/Puget Sound – Clallam, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Snohomish, Thurston, and Whatcom counties.

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

Section 2. How we change for 2005

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 and 6 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

The High Deductible Health Plan Option, is new to the FEHB program. We are being offered for the first time during the 2004 Open Season.

Program-wide changes

- In Section 10, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 13, we revised the language regarding the Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to the CDHP Plan

- Your share of the non-Postal premium will increase by 5.7% for Self Only and 5.7% for Self and Family.
- In-network preventive care (medical and dental) now is covered at 100%. (Section 5.1)
- The annual catastrophic protection out-of-pocket maximum is now \$3,000 for a Self Only enrollment, and \$6,000 for a Self and Family enrollment. (Section 4)
- For prescription drugs obtained at out-of-network retail pharmacies, you will pay 40% of the Plan allowance, except for drugs to treat sexual dysfunction for which you will pay 50% of the Plan allowance, and you also will be responsible for the difference between the Plan allowance and the billed amount. There is no out-of-network mail order pharmacy program. (Section 5.3 (f))
- We have expanded our Service Area in the State of Illinois, in the Chicago area, to include the counties of Grundy and Kendall. (See page 11)
- We have expanded our Service Area in the State of Illinois (as part of the St. Louis, MO network), to include the counties of Alexander, Bond, Calhoun, Clinton, Fayette, Jersey, Macoupin, Madison, Monroe, Montgomery, Randolph, and St. Clair. (See page 11)
- We have expanded our Service Area in the State of Indiana (as part of the Cincinnati, OH network), to include the counties of Dearborn, Franklin, Ohio, and Switzerland. (See page 11)
- We have expanded our Service Area in the State of Virginia, in the Central and Richmond, VA areas, to include the county of Culpeper. (See page 13)
- We have also expanded our Service Area to include the States of Alabama, Alaska, Arizona, Arkansas, Colorado, Delaware, Florida, Kansas, Kentucky, Massachusetts, Michigan, Mississippi, Missouri, Nevada, New Hampshire, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas. (See pages 11 - 13 for a detailed description of the Service Areas)

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 1-800/537-9384 or request them through our Web site at www.aetna.com/fed.

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/fed 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/fed 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.

• Traditional 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 FEBH 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 Member Services immediately at 1-800/537-9384. 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 1-800/537-9384 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 intravenous immunoglobulin (IVIG) 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 1-800/537-9384 for authorization.

Section 4. Your costs for covered services

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

Copayments

A copay is the fixed amount of money you pay to the pharmacy when you receive services.

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.

Consumer Driven Health Plan (CDHP)

After you have exhausted your Medical Fund, you must satisfy your deductible before your Traditional Medical Coverage begins. For the CDHP, 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 members. The full Family deductible must be met for the plan of benefits to apply. There is no individual limit within the Family deductible.

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.

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

High Deductible Health Plan (HDHP)

You must satisfy your deductible before your Traditional Medical Coverage begins. For the HDHP, your deductible is \$2,500 for a Self Only enrollment and \$5,000 for a Self and Family enrollment. The Self and Family deductible can be satisfied by one or more members. The full Family deductible must be met for the plan of benefits to apply. There is no individual limit within the Family deductible.

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.

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: You pay 15% of our Plan allowance for in-network durable medical equipment under CDHP, and 10% under HDHP.

Differences between our Plan allowance and the bill

- Network Providers agree to accept our Plan allowance so if you use a network provider, you never have to worry about paying the difference between our Plan allowance and the billed amount for covered services.
- Non-Network Providers: If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount.

Your catastrophic protection out-of-pocket maximum

CDHP

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

Self Only: Your annual out-of-pocket maximum is \$3,000.

Self and Family: Your annual out-of-pocket maximum is \$6,000.

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

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

HDHP

Self Only: Your annual out-of-pocket maximum is \$4,000.

Self and Family: Your annual out-of-pocket maximum is \$8,000.

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

- Any expenses paid by the Plan under your In-network Preventive Care benefit
- Expenses in excess of our allowance or maximum benefit limitations or expenses not covered under the Traditional Medical Coverage
- Any coinsurance expenses you have paid for infertility services
- The \$500 penalty for failure to obtain precertification when using a Non-network facility and any other amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements
- 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: For the CDHP, once you have exhausted your Medical Fund, paid your deductible, and satisfied your out-of-pocket maximums, eligible medical expenses will be covered at 100%. For the HDHP, once you have paid your deductible and satisfied your out-of-pocket maximums, eligible medical expenses will be covered at 100%.

**Section 5. Consumer Driven Health Plan
Benefits – OVERVIEW**

(See page 14 for how our benefits changed this year and page 114 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 7; 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 1-800/537-9384 or at our Web site at www.aetna.com/fed.

The Aetna HealthFund Consumer Driven Health Plan (CDHP) focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. With this Plan, eligible in-network medical and dental preventive care is covered in full, 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 CDHP Plan includes three key components:

5.1 In-Network Medical and Dental Preventive Care..... 22

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

5.2 Aetna HealthFund (Medical and Dental Funds)..... 25

The Plan 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 Plan. 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 Medical and Dental Preventive Care benefits paid under Section 5.1 do NOT count against your Medical or Dental Funds.

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)..... 29

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% for out-of-network care.

- (a) Medical services and supplies provided by physicians and other health care professionals..... 30
- (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 services..... 41
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- (g) Special features..... 49
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Section 5.1 In-Network Medical and Dental Preventive Care

Here are some important things you should keep in mind about these in-network medical and dental preventive care benefits:

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- The Plan pays 100% for the medical and dental preventive care services listed in this Section as long as you use a network provider.
- If you choose to access preventive care with an out-of-network provider, you will not qualify for 100% preventive care coverage. Please see Section 5.2 – Medical and Dental Fund, Section 5.3 – Traditional Medical Coverage (Subject to the Deductible).
- For preventive care not listed in this Section or preventive care from a non-network provider, please see Section 5.2 – Medical and Dental Funds.
- For all other covered expenses, please see section 5.2 – Medical and Dental Funds and Section 5.3 – Traditional Medical Coverage (Subject to the Deductible).
- Note that the in-network medical and dental preventive care paid under this Section does NOT count against or use up your Medical or Dental Fund.
- 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
<p>In-Network Medical Preventive Care, adult</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Blood test • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test yearly starting at age 50, – 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 annual digital rectal exam (DRE) for men age 40 and older • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • Routine mammogram — covered for women age 35 and older, as follows: <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>In-network: Nothing at a network provider.</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>

In-Network Medical Preventive Care, adult <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Routine physicals: <ul style="list-style-type: none"> – One exam every 24 months up to age 65 – One exam every 12 months age 65 and older • Routine immunizations and exams, limited to: <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.</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, athletic exams or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<p><i>All charges.</i></p>
In-Network Medical 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.</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, athletic exams or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<p><i>All charges.</i></p>

In-Network Dental Preventive Care	You pay
<p>Preventive care limited to:</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year • Fluoride applications (limited to 1 treatment per calendar year and for children under age 16) • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing x-rays (one set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year) 	<p>In-network: Nothing at a network dentist</p> <p>Out-of-network: Nothing at a non-network dentist up to your available Dental Fund balance. However, you are responsible for non-network dentist fees that exceed our Plan allowance. See Section 5.2 Dental Fund.</p>

Section 5.2 Medical and Dental Funds

Here are some important things you should keep in mind about your Medical Fund:

- All eligible medical care expenses up to the Plan allowance in Section 5.3 (except in-network preventive care) are paid first from your Medical Fund. Traditional Medical Coverage will only start once your Medical Fund is exhausted and your deductible is satisfied.
- Note that in-network preventive care covered under Section 5.1 does NOT count against your Medical Fund.
- The Medical Fund provides full coverage for eligible expenses from both in-network and non-network providers. However, your Medical Fund will generally go much further when you use network providers because network providers agree to discount their fees.
- 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 1-800/537-9384 (toll-free), or, when you incur claims, 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.
- Medicare premium reimbursement – Medicare participating annuitants may request reimbursement for Medicare premiums paid if Health Fund dollars are available. Please contact us at 1-800/537-9384 for more information.
- 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.

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Benefit Description	You pay						
<p>Medical Fund</p> <p>A Medical Fund 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 border="0" 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> <p>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> <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><u>Medical Fund Rollover</u></p> <p>Provided you remain enrolled in the CDHP, 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>	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. However, you are responsible for non-network medical fees that exceed our Plan allowance.</p>
Balance in Medical Fund for Self Only	\$ 1,000						
Less: Cost of visit	<u> - 60</u>						
Remaining Balance in Medical Fund	\$ 940						
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses and contact lenses (see the non-FEHBP page for our Vision One Program)</i> • <i>Non-network preventive care services not included under Section 5.1</i> • <i>Services or supplies shown as not covered under Traditional Medical Coverage (see Section 5.3)</i> • <i>Charges of non-network providers that exceed our Plan allowance.</i> 	<p><i>All charges.</i></p>						

Dental Fund

Here are some important things you should keep in mind about your Dental Fund:

- Note that in-network preventive dental care covered under Section 5.1 does NOT count against your Dental Fund.
- When you join this Plan, 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/fed to find a participating network PPO dentist, or call Member Services at 1-800/537-9384.
- 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 1-800/537-9384. 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						
<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 cannot be rolled over to the next year.</p> <p>Eligible dental covered services include:</p> <p>Diagnostic and Preventive Care From Non-Network Dentists:</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year • Fluoride applications (limited to 1 treatment per calendar year and 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. However, you are responsible for non-network dentist fees that exceed our Plan allowance.</p> <p>Note: Once your Dental Fund is exhausted, you pay the negotiated rates offered by participating network PPO dentists. You are responsible for the full charges for services accessed from a non-network dentist.</p>
Balance in Dental Fund for Self Only	\$ 300						
Less: Cost of visit	<u>– 125</u>						
Remaining Balance in Dental Fund	\$ 175						

Dental Fund <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing x-rays (one set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year) 	<p>Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance.</p> <p>Note: Once your Dental Fund is exhausted, you pay the negotiated rates offered by participating network PPO dentists. You are responsible for the full charges for services accessed from a non-network dentist.</p>
<p>Restorative Care (Basic and Major):</p> <ul style="list-style-type: none"> • Amalgam and resin-based composite restorations (“fillings”) • Inlays and onlays • Crowns • Fixed partial dentures (“bridgework”) • Root canal (“endodontics”) therapy, including necessary x-rays • Extractions (oral surgery) such as simple, surgical, soft tissue and bony impacted teeth • Osseous surgery (“periodontics”) - one per quadrant every 3 years, from the last date of service • General anesthesia and intravenous sedation • Repairs to removable partial dentures and complete dentures, within 6 months of installation • Occlusal guards (for bruxism only) – limited to one every 3 years, from the last date of service 	<p>Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance.</p> <p>Note: Once your Dental Fund is exhausted, you pay the negotiated rates offered by participating network PPO dentists. You are responsible for the full charges for services accessed from a non-network dentist.</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>Replacement of crowns, fixed partial dentures (bridges), removable partial dentures or complete dentures, if the existing crown, fixed partial denture (bridge), removable partial denture or complete denture was originally placed less than 8 years prior to the 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)**

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% under Section 5.1 and does not count against your Medical Fund.
- Your Medical Fund of \$1,000 for Self Only enrollment and \$2,000 for Self and Family enrollment **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. Your deductible is \$1,000 for Self Only enrollment and \$2,000 for Self and Family enrollment.
- 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 10 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
<p>Deductible before Traditional Medical Coverage begins</p> <p>Once your Medical Fund has been exhausted, you must satisfy your deductible before your Traditional Medical Coverage begins. 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>

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

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

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- The deductible is \$1,000 for Self Only enrollment and \$2,000 for Self and Family enrollment 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 10 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay
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 • 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	
Tests, such as: <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 	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.

Maternity care	You pay
<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	
<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	You pay
<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 19 mIU/ml or greater on day 3 of menstrual cycle.</i> • <i>The purchase, freezing and storage of donor sperm and donor embryos.</i> 	<p><i>All charges.</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injection • Allergy serum 	<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	You pay
<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>
<p><i>Not covered: Long-term rehabilitative therapy</i></p>	<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, chronic 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: Long-term rehabilitative therapy</i></p>	<p><i>All charges.</i></p>

Speech therapy	You pay
<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: Hearing aids, testing and examinations for them</i></p>	<p><i>All charges.</i></p>
Vision services (testing, treatment and supplies)	
<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>Optic nerve imaging methods including confocal laser scanning tomography, nerve fiber layer testing or analysis and stereophotogrammetry</i> • <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	
<ul style="list-style-type: none"> • Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. <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; 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	You pay
<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. • Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.) 	<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>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 and related supplies such as needles and catheters. <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> • <i>Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities</i> 	<p><i>All charges.</i></p>

Home health services	You pay
<ul style="list-style-type: none"> • Home health care ordered by your 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>
<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> • <i>Services provided by a family member or resident in the member's home.</i> • <i>Services rendered at any site other than the member's home.</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	
<p>We offer the following Aetna disease management programs at no cost to you:</p> <ul style="list-style-type: none"> • Chronic heart failure • Coronary artery disease • Diabetes • Asthma <p>To request more information on our disease management programs, call 1-800/537-9384. Also see the Non-FEHB page for our Fitness Program.</p>	<p>Nothing</p>

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

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

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- The deductible is \$1,000 for Self Only enrollment and \$2,000 for Self & Family enrollment.
- 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 10 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
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 5.3(a) – Orthopedic and prosthetic devices 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>

Surgical procedures <i>(continued)</i>	You pay
<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 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 of conditions of the foot; see Foot care</i> 	<p><i>All charges.</i></p>
<p>Reconstructive surgery</p> <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 and developmental anomalies are: cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. All surgical requests must be preauthorized. • 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 (<i>see Prosthetic devices</i>) <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	You pay
<p>Oral surgical procedures, that are medical in nature, such as:</p> <ul style="list-style-type: none"> • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ, must be preauthorized; and • Excision of tumors and cysts. <p>Note: When requesting oral and maxillofacial services, please check DocFind or call Member Services at 1-800/537-9384 for a participating oral and maxillofacial surgeon.</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>Dental implants</i> • <i>Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> 	<p><i>All charges.</i></p>
Organ/tissue transplants	
<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) 	<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 next page.

Organ/tissue transplants (<i>continued</i>)	You pay
<ul style="list-style-type: none"> • 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 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 testicular cancers <p>Limited Benefits — Treatment for breast cancer, multiple myeloma and 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>
<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>
<p>Anesthesia</p>	
<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>Nothing</p>

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

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

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- The deductible is \$1,000 for Self Only enrollment and \$2,000 for Self & Family enrollment.
- 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 10 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
<p>Inpatient hospital</p> <p>Room and board, such as</p> <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> <p>Other hospital services and supplies, such as:</p> <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 prolactin • 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. 	<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>

Inpatient hospital - continued on next page.

Inpatient hospital <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Whole blood and concentrated red blood cells not replaced by the member • Non-covered facilities, such as nursing homes, schools • Custodial care, rest cures, domiciliary or convalescent cares • Personal comfort items, such as telephone and television • Private nursing care 	<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: Whole blood and concentrated red blood cells not replaced by the member.</i></p>	<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: Custodial care</i></p>	<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: Ambulance services for routine transportation to receive outpatient or inpatient services.</i></p>	<p><i>All charges.</i></p>

Section 5.3(d) Emergency services/accidents

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

- The deductible is \$1,000 for Self Only enrollment and \$2,000 for Self & Family enrollment.
- 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 10 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
Emergency	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office or urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services 	In-network: 15% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
<ul style="list-style-type: none"> • Non-emergency use of the Emergency Room 	50% of our Plan allowance
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Ambulance	
Professional ambulance service when medically appropriate. Air ambulance may be covered. Prior approval is required. See Hospital section for non-emergency service.	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.
<i>Not covered: Air ambulance without prior approval.</i>	<i>All charges.</i>

Section 5.3(e) Mental health and substance abuse benefits

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When you get our approval for 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 you should keep in mind about these benefits:

- The deductible is \$1,000 for Self Only enrollment and \$2,000 for Self & Family enrollment.
- 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 10 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT SERVICES.**

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Benefit Description	You pay
Mental health and substance abuse benefits	
<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 you should keep in mind about these benefits:

- The deductible is \$1,000 for Self Only enrollment and \$2,000 for Self & Family enrollment.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page. Copayment levels reflect in-network pharmacies only. If you obtain your prescription at an out-of-network pharmacy (non-preferred), you will be reimbursed at our Plan allowance less 40%. You are responsible for any difference between our Plan allowance and the billed amount.
- Your Medical Fund **must** be used first for eligible pharmacy expenses and your deductible must be satisfied before your Traditional Medical Coverage begins. You will then pay a copayment at in-network retail pharmacies or mail-order pharmacy for prescriptions under your Traditional Medical Coverage. You will pay 40% coinsurance plus the difference between our Plan allowance and the billed amount at out-of-network retail pharmacies. There is no out-of-network mail order pharmacy program.
 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 10 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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There are important features you should be aware of 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 1-800/537-9384 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/fed to review our Formulary Guide or call 1-800/537-9384.
- **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 (applies to in-network pharmacies only). 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 do have to file a claim.** Send your itemized bill(s) to: Aetna, Pharmacy Management, Claim Processing, P.O. Box 398106, Minneapolis, MN 55439-8106.

Benefit Description	You pay
<p>Covered medications and supplies</p> <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 or an out-of-network retail pharmacy:</p> <ul style="list-style-type: none"> • Drugs and medicines 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 • Insulin • Disposable needles and syringes for the administration of covered medications 	<p>In-network:</p> <p>The full cost of the prescription is applied to the deductible before any benefits are considered for payment under the pharmacy plan. Once the deductible is satisfied, the following will apply:</p> <p>Retail Pharmacy, for up to a 30-day supply per prescription or refill:</p> <p>\$10 per covered generic formulary drug; \$25 per covered brand name formulary drug; and \$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 \$50 per covered brand name formulary drug; and \$80 per covered non-formulary (generic or brand name) drug.</p> <p>Out-of-network (retail pharmacies only):</p> <p>40% plus the difference between our Plan allowance and the billed amount.</p>

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>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 Medication Formulary Guide, call 1-800/537-9384. 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/fed for current Medication Formulary Guide information. 	<p>In-network:</p> <p>50%</p> <p>\$25/kit</p> <p>\$25 copay per vial</p> <p>\$25 per diaphragm</p> <p>Out-of-network (retail pharmacies only):</p> <p>40% plus the difference between our Plan allowance and the billed amount, except for drugs to treat sexual dysfunction which are 50% plus the difference between our Plan allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs used for the purpose of weight reduction, such as appetite suppressants</i> • <i>Drugs for cosmetic purposes, such as 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) Special features

Feature	Description
Aetna IntelliHealth®	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/fed .
Aetna Navigator™	<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/fed.</p>
Informed Health® Line	Provides eligible members with telephone access to registered nurses experienced in providing information on a variety of health topics. Informed Health Line is available 24 hours a day, 7 days a week. You may call Informed Health Line at 1-800/556-1555. 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.
Services for the deaf and hearing-impaired	1-800/628-3323

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

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[™] Program offers 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.

¹ Vision One is a registered trademark of Cole Vision Corporation.

**Section 6. High Deductible Health Plan (HDHP)
Benefits – OVERVIEW**

(See pages 116 - 118 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 section. Also read the General Exclusions in Section 7; 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 1-800/537-9384 or at our Web site at www.aetna.com/fed.

Aetna’s high deductible health plan option with an HSA provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP option, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you based on your eligibility. Under the HSA, we automatically pass through a portion of the total health Plan premium to your HSA each month, based upon your eligibility. If we establish an HRA for you, we will credit your account with the full amount. If we establish an HSA for you, we will credit your account monthly.

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

This HDHP includes five key components: in-network medical and dental preventive care; traditional medical coverage that is subject to the deductible; savings, catastrophic protection for out-of-pocket expenses, and, health education resources and account management tools.

6.1 Savings – Health Savings Account or Health Reimbursement Arrangement54

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see Sections 6.1(a), 6.1(b), and 6.1(c) for more details).

6.1(a) Health Savings Account (HSA).....55

By law, HSAs are available to members who cannot be claimed as a dependent on someone else’s tax return, have not received VA benefits within the previous three months, and who are not enrolled in Medicare or do not have other health insurance coverage, other than another high deductible health plan. In 2005, for each month you are eligible for the HSA, we will deposit \$104.16 per month for a Self Only enrollment or \$208.33 per month for a Self and Family enrollment to your HSA. In addition to our monthly deposit, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$1,250 for Self Only enrollment and \$2,500 for Self and Family enrollment. See maximum contribution information in Section 6.1(c). You can use funds in your HSA to help pay your health plan deductible and other medical expenses.

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

HSA features include:

- Your HSA is administered by Aetna Life Insurance Company
- Your contributions to the HSA are tax deductible
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.)
- Your unused HSA funds and interest accumulate from year to year
- It’s portable – the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available.

Important Consideration if you want to participate in a Health Care Flexible Spending Account: if you are enrolled in this HDHP with a Health Savings Account (HSA), you are not able to participate in an *FSAFEDS* Health Care Flexible Spending Account (HCFSA). See The Federal Flexible Spending Account Program – *FSAFEDS* in Section 13.

6.1(b) Health Reimbursement Arrangement (HRA)58

For members who aren't eligible for an HSA, are enrolled in Medicare or have another health plan, Aetna will administer and provide an HRA.

In 2005, we will give you an HRA credit of \$1,250 per year for a Self Only enrollment and \$2,500 for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Aetna Life Insurance Company
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an *FSAFEDS* Health Care Flexible Spending Account (HCFSA). However, you must meet *FSAFEDS* eligibility requirements. See *Who Is Eligible to Enroll?* in Section 13 under The Federal Flexible Spending Account Program – *FSAFEDS*.

6.1(c) Savings – HSA and HRA Comparisons60

Important information that compares features of HSAs and HRAs, as well as gives answers to frequently asked questions.

6.2 In-network Medical and Dental Preventive Care66

The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., routine mammograms), routine prenatal and well-child care, routine child and adult immunizations, disease management and wellness programs. These services are covered at 100% if you use a network provider and are fully described in Section 6.2. *You do not have to meet the deductible before using these services.* This does not reduce your Account or Fund.

6.3 Traditional Medical Coverage (Subject to the Deductible).....69

After you have paid the Plan's deductible (\$2,500 for Self Only enrollment and \$5,000 for Self and Family enrollment), we pay benefits under Traditional Medical Coverage (Subject to the Deductible) described in Section 6.3. The Plan typically pays 90% for in-network and 70% for out-of-network care.

Covered services include:

- (a) Medical services and supplies provided by physicians and other health care professionals70
- (b) Surgical and anesthesia services provided by physicians and other health care professionals77
- (c) Hospital services; other facility or ambulance services81
- (d) Emergency services/accidents84
- (e) Mental health and substance abuse benefits85
- (f) Prescription drug benefits86
- (g) Special features89

6.4 Catastrophic protection for out-of-pocket expenses90

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$4,000 per person or \$8,000 per family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 *Your catastrophic protection out-of-pocket maximum* and Section 6.3 *Traditional Medical Coverage (Subject to the Deductible)*, and Section 6.4 *Catastrophic protection for out-of-pocket expenses* for more details.

6.5 Health education resources and account management tools.....91

Section 6.5 describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Connect to www.aetna.com/fed for access to Aetna Navigator, a secure and personalized member site offering you a single source for health and benefits information. Use it to:

- Perform self-service functions, like checking your fund and deductible balance or the status of a claim.
- Gather health-related information from our award-winning Aetna IntelliHealth® website, one of the most comprehensive health sites available today.

Navigator gives you direct access to:

- The Price-A-Medical ProcedureSM tool, to compare network physician fees for select services to typical fees outside the network.
- Price-A-DrugSM tool to estimate the cost of your prescription if obtained at a participating retail or mail order pharmacy.
- A hospital comparison tool that allows you to see how hospitals in your area rank on measures important to your care.
- Our DocFind® online provider directory.
- Online customer service that allows you to request member ID cards, send secure messages to Member Services, and more.
- Simple Steps To A Healthier Life™ where you assess your potential health risks, develop a personalized action plan for better health, track your progress and much more.
- Healthwise® Knowledgebase where you get information on thousands of health-related topics to help you make better decisions about your health care and treatment options.

**Section 6.1 Savings – Health Savings Account or
Health Reimbursement Arrangement**

Here are some important things you should keep in mind about a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA):

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- Enrollment in a High Deductible Health Plan (HDHP), with an HSA or HRA, provides health benefits coverage and a tax-advantaged way to help save for future medical expenses.
- The HDHP/HSA or HRA gives you greater flexibility and discretion over how you use your health care dollars.
- An HSA is a trust account that you own for the purpose of paying qualified medical expenses for yourself, your spouse, and other dependents. See Sections 6.1(a) and 6.1(c) for greater detail.
- An HRA is an employer-funded account that automatically reimburses allowable medical expenses, and is administered by the health plan. See Sections 6.1(b) and 6.1(c) for greater detail.

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Section 6.1(a) Health Savings Account (HSA)

Here are some important things you should keep in mind about your HSA:

- You can choose how to use your HSA. You can save your HSA for future expenses while utilizing other funds. Or you can use your HSA account to pay for claims (subject to the deductible).
- You must participate in the Aetna HealthFund High Deductible Health Plan (HDHP) option, have no other insurance coverage other than that permitted, and not be claimed as a dependent on someone else’s tax return, in order to be eligible for an HSA. Some examples of other coverage that would cause ineligibility are: enrollment in a health care spending account component of a flexible spending account (FSA), a spouse’s FSA, enrollment in a spouse’s health care spending account component of an HMO, other non-high deductible health coverage, TRICARE, Medicare Part A or B or receipt of VA benefits within the previous three months. You are responsible for notifying us of any changes that would cause you to become ineligible.
- All eligible medical expenses in Section 6.3 (except in-network preventive care) are applied to your deductible. Traditional Medical Coverage (Subject to the Deductible) will only start once your deductible is satisfied.
- Your HSA can be used to pay for “qualified medical expenses,” as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving federal unemployment compensation, over-the-counter drugs, LASIK surgery and some nursing services. When you enroll in Medicare, you can use the account to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you enroll in Medicare. For a list of IRS-allowable expenses, you can request a copy of IRS Publication 502 by calling 1-800/829-3676, or visit the IRS website at www.irs.gov and click on “Forms and Publications.”
- You have flexibility about how to spend your dollars, and the Plan provides you with the resources to manage your HDHP. You can track your HDHP on Aetna’s Navigator Web site or by telephone at 1-800/537-9384 (toll-free).
- You may contribute to your HSA by submitting a lump sum payment via a check in any amount, up to the maximum allowed. To make a lump sum contribution, complete an HSA Contribution form and submit it along with your check to the address listed on the form. The deadline for HSA contributions is April 15 following the year for which contributions are made. When you submit the HSA Contribution form, please be sure to indicate whether your contribution is for the current tax year or the previous tax year. You can obtain additional HSA forms by logging into the Aetna Navigator website at www.aetnavigators.com, enrolling as a member, and selecting from the “Forms Library.”
- If you join this Plan during Open Season, you receive the full HSA (\$1,250 for Self Only or \$2,500 for Self and Family enrollment) as of your effective date of coverage. If you join at any other time during the year, your permitted HSA contribution levels are prorated by month. If you join other than the first of the month, you are eligible to contribute to your HSA at the beginning of the first full month of coverage.
- If you change from Self Only enrollment to Self and Family enrollment mid-year, you can credit amounts incurred against your individual deductible toward your family deductible.
- You may not contribute to an HSA once you are enrolled in Medicare. Please contact us at 1-800/537-9384 for more information.
- 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
<p>Health Savings Account</p> <p>A Health Savings Account is administered by the Plan for each enrollment. Each year the Plan adds to your HSA:</p> <ul style="list-style-type: none"> • \$1,250 per year for a Self Only enrollment, or; • \$2,500 per year for a Self and Family enrollment. <p>You may also contribute the following to your HSA:</p> <ul style="list-style-type: none"> • Up to \$1,250 per year for a Self Only enrollment, or • Up to \$2,500 per year for a Self and Family enrollment. <p>Note: If you join the Plan other than the first of the month, you are eligible to contribute to your HSA at the beginning of the first full month of coverage.</p> <p>Computing the Maximum Allowable Contribution to an HSA Account</p> <p>The annual deductible is divided by 12. The result is multiplied by the number of full months remaining in the year after the effective date of the HDHP.</p> <ul style="list-style-type: none"> • Example #1: Effective date of enrollment in the Aetna HDHP is 1/9/05. The annual family deductible is \$5,000. The maximum allowable 2005 contribution to an HSA account for the enrollee is $\\$5,000 \times 11/12 = \\$4,583.33$. You may make a contribution of up to \$2,083.33 (\$4,583.33 – \$2,500 automatic Plan contribution from premium). • Example #2: Effective date of enrollment in Aetna HDHP is 7/6/05. The annual Self Only deductible is \$2,500. The maximum allowable 2005 contribution to an HSA account for the enrollee is $\\$2,500 \times 5/12 = \\$1,041.67$. You may make a contribution of up to \$520.87 (\$1,041.67 - \$520.80 automatic Plan contribution from premium). <p>Reimbursement of Medical Expenses from HSA</p> <p>To be a “qualified medical expense,” eligible for reimbursement from the HSA, the medical expense must be incurred on or following the effective date of the HSA. The HSA effective date is the day the account is established, but not before the first day of the month on or following the effective date of the HDHP.</p> <ul style="list-style-type: none"> • Example #1: Effective date of HDHP enrollment is 1/9/05 and HSA is established on 1/11/05. Therefore, the HSA effective date is 2/1/05. Only medical expenses incurred on or after 2/1/05 are reimbursable from the HSA. If the effective date of the HDHP were instead 1/1/05, then the HSA would be effective on the date it was established and medical expenses incurred on or after 1/11/05 would be reimbursable from the HSA. • Example #2: Effective date HDHP enrollment is 1/9/05 and HSA is established on 2/5/05. Only medical expenses incurred on or after 2/5/05 are reimbursable. <p>Under the HSA, you can choose to pay from other funds and allow your HSA to grow over time.</p>	<p>Nothing for eligible expenses</p>

Health Savings Account <i>(continued)</i>	You pay
<p>To make the most of your eligible expenses, you should:</p> <ul style="list-style-type: none"> • Use the network providers whenever possible; and • Use generic prescriptions whenever possible <p><u>HSA Rollover</u></p> <p>Any unused, remaining balance in your HSA at the end of the calendar year carries over to the next year. You own your account, so you keep your HSA account even if you change health plans or jobs. If you no longer are enrolled in a high deductible health plan, you are not eligible to make new contributions to your HSA, but you may request a withdrawal for qualified medical expenses.</p> <p>Note: There is no rollover maximum.</p>	<p>Nothing for eligible expenses</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Non-network preventive care services not included under Section 6.1</i> • <i>Services or supplies shown as not covered under Traditional Medical Coverage (see Section 6.3)</i> • <i>Charges of non-network providers that exceed our Plan allowance.</i> 	<p><i>All charges.</i></p>

Section 6.1(b) Health Reimbursement Arrangement (HRA)

Here are some important things you should keep in mind about your HRA:

- Members must be enrolled in Medicare.
- The Plan provides an HRA Fund for each enrollment for members enrolled in Medicare. Each year, the Plan provides \$1,250 for a Self Only enrollment or \$2,500 for a Self and Family enrollment. The HRA covers 100% of your eligible medical expenses, and applies to your deductible of \$2,500 for Self Only enrollment and \$5,000 for Self and Family enrollment.
- All eligible health care expenses in Section 6.3 (except in-network preventive care) are paid first from your HRA. Traditional Medical Coverage will only start once your HRA Fund is exhausted and your deductible is satisfied.
- If you have an unused HRA Fund balance at the end of the calendar year, you will rollover that balance so you can use it in the future with no maximum rollover amount, as long as you continue to participate in the Plan. If you terminate your participation in the Plan, your HRA balance is lost.
 Note: In-network Preventive Care benefits paid under Section 6.2 do NOT account against your HRA.
- Medicare premium reimbursement – Medicare participating annuitants may request reimbursement for Medicare premiums paid if HRA dollars are available. Please contact us at 1-800/537-9384 for more information.
- You have flexibility about how to spend your HRA Fund, and the Plan provides you with the resources to manage your HRA Fund. You can track your HRA Fund on Aetna’s Navigator Web site at www.aetna.com/fed or by telephone at 1-800/537-9384 (toll-free).
- If you join this Plan during Open Season, you receive the full HRA Fund (\$1,250 per Self Only or \$2,500 per Self and Family enrollment) as of your effective date of coverage. If you join at any other time during the year, your HRA Fund for your first year will be prorated at a rate of \$104.16 per month for Self Only or \$208.33 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.
- **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.

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Benefit Description	You pay						
Health Reimbursement Arrangement							
<p>An HRA Fund is provided by the Plan for each enrollment. Each year the Plan adds to your HRA:</p> <ul style="list-style-type: none"> • \$1,250 per year for a Self Only enrollment, or; • \$2,500 per year for a Self and Family enrollment. <p>The HRA 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 HRA; you pay nothing.</p> <table border="0" data-bbox="198 625 766 751"> <tr> <td>Balance in HRA Fund for Self Only</td> <td style="text-align: right;">\$1,250</td> </tr> <tr> <td>Less: Cost of visit</td> <td style="text-align: right;"><u> - 60</u></td> </tr> <tr> <td>Remaining Balance in HRA Fund</td> <td style="text-align: right;">\$1,190</td> </tr> </table> <p>To make the most of your eligible expenses, you should:</p> <ul style="list-style-type: none"> • Use the network providers whenever possible; and • Use generic prescriptions whenever possible. <p><u>HRA Rollover</u></p> <p>Provided you remain enrolled in the HRA, any unused, remaining balance in your HRA Fund at the end of the calendar year may be rolled over to subsequent years.</p> <p>Note: There is no rollover maximum.</p>	Balance in HRA Fund for Self Only	\$1,250	Less: Cost of visit	<u> - 60</u>	Remaining Balance in HRA Fund	\$1,190	<p>Nothing for eligible expenses.</p>
Balance in HRA Fund for Self Only	\$1,250						
Less: Cost of visit	<u> - 60</u>						
Remaining Balance in HRA Fund	\$1,190						
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Non-network preventive care services not included under Section 6.1</i> • <i>Services or supplies shown as not covered under Traditional Medical Coverage (see Section 6.3)</i> • <i>Charges of non-network providers that exceed our Plan allowance.</i> 	<p><i>All charges.</i></p>						

Section 6.1(c) Savings – HSA and HRA Comparisons

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	<p>The Plan will establish an HSA for you with Aetna Life Insurance Company, this HDHP’s fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS).</p> <p>Aetna Life Insurance Company 920B Harvest Drive, U40A Blue Bell, PA 19422 1-800/537-9384 www.aetna.com/fed</p>	<p>Aetna Life Insurance Company is the HRA fiduciary for this Plan.</p> <p>Aetna Life Insurance Company 920B Harvest Drive, U40A Blue Bell, PA 19422 1-800/537-9384 www.aetna.com/fed</p>
Fees	<p>Set-up fee is paid by the Plan.</p> <p>The administrative fee is covered in the premium while the member is covered under the HDHP. If you are no longer covered under the HDHP, there is a \$0.75 administrative fee that will be deducted from your HSA until it reaches zero.</p>	None.
Eligibility	<ul style="list-style-type: none"> • You must be enrolled in the Aetna HealthFund High Deductible Health Plan (HDHP). • You must not be enrolled in Medicare Part A or Part B or have other general medical insurance coverage. • You must not be a dependent on someone else’s tax return. • You must not have received VA benefits in the last 3 months. 	<ul style="list-style-type: none"> • You must be enrolled in the Aetna HealthFund High Deductible Health Plan (HDHP). • If you enroll in Aetna’s HSA and do not qualify for an HSA, we will establish an HRA for you. • You must be enrolled in Medicare. • Eligibility is determined on the first day of the month.

High Deductible Health Plan

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
<p>Funding</p> <ul style="list-style-type: none"> • Self Only coverage • Self and Family coverage 	<p>\$1,250 annually – prorated monthly and deposited by the Plan directly into your account. The Plan will make a monthly deposit of \$104.16. Your annual maximum contribution cannot exceed \$2,500.</p> <p>\$2,500 annually – prorated monthly and deposited by the Plan directly into your account. The Plan will make a monthly deposit of \$208.33. Your annual maximum contribution cannot exceed \$5,000.</p> <p>Eligibility for contributions will be determined on the first day of the month following your effective date of coverage and will be prorated for length of enrollment.</p>	<p>\$1,250 annual credit provided by the HDHP upon effective date.</p> <p>\$2,500 annual credit provided by the HDHP upon effective date.</p> <p>Eligibility for annual credit will be determined on the first day of the month and will be prorated for length of enrollment.</p>
<p>Contributions/credits</p>	<p>The maximum that can be contributed to your HSA is an annual combination of the automatic contribution from the Plan which is deposited into the Account and voluntary enrollee contributions, which when combined, cannot exceed the amount of the deductible, which is \$2,500 for Self Only coverage and \$5,000 for Self and Family coverage.</p>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.</p>
	<p>If you choose to contribute to your HSA,</p> <ul style="list-style-type: none"> – You must deduct 1/12 of total annual maximum contribution for every month you are not eligible for the HDHP the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution. – You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). – Your HSA will earn tax-free interest (does not affect your annual maximum contribution). 	

High Deductible Health Plan

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Access funds	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Withdrawal form <p>OR</p> <ul style="list-style-type: none"> • Streamlining (all eligible medical expenses would automatically flow to the HSA and payment would be made directly to the account holder). (Note: member needs to enroll in this option.) 	<p>For qualified medical expenses under your HDHP, claims will be paid automatically by your HRA when claims are submitted to Aetna, if there is money available in your HRA.</p>
Distributions/withdrawals • Medical	<p>After meeting the deductible, pay the out-of-pocket expenses for yourself, your spouse or your dependents even if they are not covered by the HDHP from the funds available in your HSA.</p> <p>Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from your HSA until the first of the month following the effective date of your enrollment in this HDHP and the date your HSA account is established.</p> <p>For most Federal enrollees (those not paid on a monthly basis), the earliest date medical expenses will be allowable is February 1, 2005.</p> <p>See IRS Publication 502 for a complete list of eligible expenses.</p>	<p>After meeting the deductible, pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a complete list of eligible expenses.</p>
• Non-medical	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the accumulated funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.</p>

High Deductible Health Plan

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Availability of Account or Fund	<p>Funds are not available until:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • Aetna sends out HSA enrollment forms and Disclosure Statement paperwork for the enrollee to complete and the plan administrator receives the completed paperwork. <p>After the plan administrator receives enrollment and contributions from OPM, the enrollee can withdraw funds up to the amount contributed for any expenses incurred on or after the date the HSA was initially established.</p>	<p>Funds are not available until:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change).
Account owner	FEHB enrollee	HDHP
Portable	Yes, you can take this account with you when you separate or retire.	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
Annual rollover	Yes, accumulates without a maximum annual cap.	Yes, accumulates without a maximum annual cap.

HSAs

Is the “premium pass through” to my HSA considered taxable income?

“Premium pass through” contributions by the HDHP are not considered taxable income.

Can I contribute to my HSA?

Yes. All contributions are aggregated and cannot exceed the annual maximum contribution. You may contribute your own money to your account through payroll deductions (if available), or you may make a lump sum contribution at any time, in any amount up to an annual maximum limit. Others can also make contributions to your HSA on your behalf. If you (or someone on your behalf) contribute a lump-sum, you can claim the total amount contributed for the year as a tax deduction when you file your income taxes. You receive tax advantages in any case. You have until April 15 of the following year to make HSA contributions for the current year.

IRS contribution rules reduce the total annual maximum contribution if you are not eligible for the HDHP during the whole month. For instance, if your enrollment in this Plan was not effective on January 1, 2005, you cannot receive a credit for January and you would need to deduct 1/12 of the annual maximum contribution. Contact Aetna for more details.

Catch-up contributions

If you are age 55 or older, the IRS permits you to make additional catch-up contributions to your HSA. In 2005, you may contribute up to \$600 in “catch-up” contributions. Catch-up contributions in later years increase up to a maximum of \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the IRS Web site at www.irs.gov.

Rate of interest earned

Depending on how you choose to invest your HSA savings, the interest rate and payment of interest will vary.

What happens to my HSA if I leave my health plan or job?

You own your account, so you keep your HSA even if you change health plans, leave Federal employment, enroll in Medicare, or any of the other events which may make you ineligible for further contributions to your HSA. Even when you are not eligible to make contributions to your HSA, you may request withdrawals.

What happens to my HSA if I die?

Your HSA would pass to your surviving spouse or named beneficiary tax-free. If you do not have a named beneficiary, the money is disbursed to your estate and is taxable.

What expenses can I pay for with my HSA?

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

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

For the complete list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on “Forms and Publications.”

Non-qualified health expenses

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.

HRAs

How do I know if I qualify for an HRA?

If you don't qualify for an HSA when you enroll, or later become ineligible for an HSA, the HDHP will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and your HDHP will establish an HRA for you.

HRA and HSA differences

Please review the chart at the beginning of this Section which details the differences. The major differences are:

- you cannot make contributions to an HRA
- HRA funds are forfeited if you leave the HDHP
- an HRA does not earn interest, and
- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP.

Section 6.2 In-Network Medical and Dental Preventive Care

Here are some important things you should keep in mind about these in-network medical and dental preventive care benefits:

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- The Plan pays 100% for the medical and dental preventive care services listed in this Section as long as you use a network provider.
- If you choose to access preventive care from a non-network provider, you will not qualify for 100% preventive care coverage. Please see Section 6.2 – HSA, and HRA or Section 6.3 – Traditional Medical Coverage (Subject to the Deductible).
- For preventive care not listed in this Section, preventive care from a non-network provider, or any other covered expenses, please see Section 6.3 – Traditional Medical Coverage.
- Note that the in-network preventive care paid under this Section does NOT count against or use up your HSA or HRA.
- 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	
	HSA	HRA
In-Network Medical Preventive Care, adult		
Routine screenings, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Total Blood Cholesterol • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test yearly starting at age 50, – 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 annual digital rectal exam (DRE) for men age 40 and older • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • Routine mammogram — covered for women age 35 and older, as follows: <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 	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 30% of our Plan allowance and any difference between our allowance and the billed amount under Traditional Medical Coverage (Section 6.3). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional Medical Coverage (Section 6.3), and the deductible.

High Deductible Health Plan

In-Network Medical Preventive Care, adult <i>(continued)</i>	You pay HSA	You pay HRA
<ul style="list-style-type: none"> • Routine physicals: <ul style="list-style-type: none"> – One exam every 24 months up to age 65 – One exam every 12 months age 65 and older • Routine immunizations, exams and eyewear limited to: <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 – Corrective eyeglasses and frames or contact lenses (hard or soft) per 24-month period up to a Plan allowance of \$100. 	<p>In-network: Nothing at a network provider.</p> <p>Out-of-network: All charges until you satisfy your deductible, then 30% of our Plan allowance and any difference between our allowance and the billed amount under Traditional Medical Coverage (Section 6.3). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.</p>	<p>In-network: Nothing at a network provider</p> <p>Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional Medical Coverage (Section 6.3), 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, athletic exams or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<i>All charges.</i>	<i>All charges.</i>
In-Network Medical 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</p> <p>Out-of-network: All charges until you satisfy your deductible, then 30% of our Plan allowance and any difference between our allowance and the billed amount under Traditional Medical Coverage (Section 6.3). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.</p>	<p>In-network: Nothing at a network provider</p> <p>Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional Medical Coverage (Section 6.3), and the deductible.</p>

In-Network Medical Preventive Care, children <i>(continued)</i>	You pay HSA	You pay HRA
<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, athletic exams or travel.</i> • <i>Immunizations, boosters, and medications for travel or work-related exposure.</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
In-Network Dental Preventive Care		
<p>Preventive care limited to:</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year • Fluoride applications (limited to 1 treatment per calendar year and for children under age 16) • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing x-rays (one set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year) <p>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/fed to find a participating network PPO dentist, or call Member Services at 1-800/537-9384.</p>	<p>In-network: Nothing at a network dentist</p> <p>Out-of-network: All charges</p>	<p>In-network: Nothing at a network dentist</p> <p>Out-of-network: All charges</p>

**Section 6.3 Traditional Medical Coverage
(Subject to the Deductible)**

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network preventive care is covered at 100% under Section 6.2 and does not count against your deductible.
- The deductible is \$2,500 per person or \$5,000 per family enrollment. The family deductible can be satisfied by one or more family members. You must pay your deductible before your Traditional Medical Coverage may begin.
- Under Traditional Medical Coverage, in-network benefits apply only when you use a network provider. Out-of-network benefits apply when you do not use a network provider. Your dollars will generally go further when you use network providers because network providers agree to discount their fees.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 10 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	
	HSA	HRA
Deductible before Traditional Medical Coverage begins		
<p>You must satisfy your deductible before your Traditional Medical Coverage begins. The Self and Family deductible can be satisfied by one or more family members.</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, until you reach the annual catastrophic protection out-of-pocket maximum. At that point, we pay eligible medical expenses for the remainder of the calendar year at 100%.</p>	<p>100% of allowable charges until you meet the deductible of \$2,500 per Self Only enrollment or \$5,000 per Self and Family enrollment. You can use HSA to help satisfy your deductible.</p>	<p>100% of allowable charges until you meet the deductible of \$2,500 per Self Only enrollment or \$5,000 per Self and Family enrollment. Your HRA Fund counts towards your deductible.</p>

Section 6.3(a) Medical services and supplies provided by physicians and other health care professionals

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

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- The deductible is \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment.
- After you have 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 10 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay
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 • At home 	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Lab, X-ray and other diagnostic tests	
Tests, such as: <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 	

Maternity care	You pay
<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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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	
<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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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	You pay
<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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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 19 mIU/ml or greater on day 3 of menstrual cycle.</i> • <i>The purchase, freezing and storage of donor sperm and donor embryos.</i> 	<p><i>All charges.</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injection • Allergy serum 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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	You pay
<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 79.</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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Long-term rehabilitative therapy</i></p>	<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, chronic heart failure or a myocardial infarction is provided for up to 3 visits a week for a total of 18 visits. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Long-term rehabilitative therapy</i></p>	<p><i>All charges.</i></p>

Speech therapy	You pay
<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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Hearing aids, testing and examinations for them</i></p>	<p><i>All charges.</i></p>
Vision services (testing, treatment and supplies)	
<ul style="list-style-type: none"> • Treatment of eye diseases and injury • One routine eye refraction every 12-month period 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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>Optic nerve imaging methods including confocal laser scanning tomography, nerve fiber layer testing or analysis and stereophotogrammetry</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	
<ul style="list-style-type: none"> • Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. <p>See <i>Orthopedic and prosthetic devices</i> for more information.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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; 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	You pay
<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. • Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.) 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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>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 and related supplies such as needles and catheters. <p>Note: Some DME may require precertification by you or your physician.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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> • <i>Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities</i> 	<p><i>All charges.</i></p>

Home health services	You pay
<ul style="list-style-type: none"> • Home health care ordered by your 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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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>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> • <i>Services provided by a family member or resident in the member's home.</i> • <i>Services rendered at any site other than the member's home.</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	
<p>We offer the following Aetna disease management programs at no cost to you:</p> <ul style="list-style-type: none"> • Chronic heart failure • Coronary artery disease • Diabetes • Asthma <p>To request more information on our disease management programs, call 1-800/537-9384. Also see the Non-FEHB page for our Fitness Program.</p>	<p>Nothing</p>

Section 6.3(b) Surgical and anesthesia services provided by physicians and other health care professionals

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

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- The deductible is \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment.
- 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 10 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
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 6.3(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Surgical procedures <i>(continued)</i>	You pay
<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 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 of conditions of the foot; see Foot care</i> 	<p><i>All charges.</i></p>
<p>Reconstructive surgery</p> <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 and developmental anomalies are: cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. All surgical requests must be preauthorized. • 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 (<i>see Prosthetic devices</i>) <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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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	You pay
<p>Oral surgical procedures, that are medical in nature, such as:</p> <ul style="list-style-type: none"> • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ, must be preauthorized; and • Excision of tumors and cysts. <p>Note: When requesting oral and maxillofacial services, please check DocFind or call Member Services at 1-800/537-9384 for a participating oral and maxillofacial surgeon.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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 (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> 	<p><i>All charges.</i></p>
Organ/tissue transplants	
<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 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Organ/tissue transplants (<i>continued</i>)	You pay
<ul style="list-style-type: none"> • Allogeneic (donor) bone marrow/peripheral stem cell transplants • Autologous bone marrow 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 testicular cancers <p>Limited Benefits — Treatment for breast cancer, multiple myeloma and 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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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>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: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Section 6.3(c) Services provided by a hospital or other facility, and ambulance services

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

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- The deductible is \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment.
- 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 10 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
Inpatient hospital	
<p>Room and board, such as</p> <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> <p>Other hospital services and supplies, such as:</p> <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 prolactin • 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. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Inpatient hospital - continued on next page.

Inpatient hospital (continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Whole blood and concentrated red blood cells not replaced by the member • Non-covered facilities, such as nursing homes, schools • Custodial care, rest cures, domiciliary or convalescent cares • Personal comfort items, such as telephone and television • Private nursing care 	<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: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Whole blood and concentrated red blood cells not replaced by the member.</i></p>	<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: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All charges.</i></p>

High Deductible Health Plan

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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Ambulance services for routine transportation to receive outpatient or inpatient services.</i></p>	<p><i>All charges.</i></p>

Section 6.3(d) Emergency services/accidents

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

- The deductible is \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment.
- 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 10 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
Emergency	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office or urgent care center • Emergency care as an outpatient in a hospital, including doctors’ services 	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
<ul style="list-style-type: none"> • Non-emergency use of the Emergency Room 	50% of our Plan allowance
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Ambulance	
Professional ambulance service when medically appropriate. Air ambulance may be covered. Prior approval is required. See Hospital section for non-emergency service.	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
<i>Not covered: Air ambulance without prior approval.</i>	<i>All charges.</i>

Section 6.3(e) Mental health and substance abuse benefits

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When you get our approval for 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 you should keep in mind about these benefits:

- The deductible is \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment.
- 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 10 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR INPATIENT SERVICES.**

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Benefit Description	You pay
Mental health and substance abuse benefits	
<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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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: 10% of our Plan allowance</p> <p>Out-of-network: 30% 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 6.3(f) Prescription drug benefits

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

- The deductible is \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page. Copayment levels reflect in-network pharmacies only. If you obtain your prescription at an out-of-network pharmacy (non-preferred), you will be reimbursed at our Plan allowance less 30%. You are responsible for any difference between our Plan allowance and the billed amount.
- Your deductible must be satisfied before your Traditional Pharmacy Coverage begins. After your deductible is satisfied, you will pay a copayment at an in-network retail or mail order pharmacy for prescriptions under your Traditional Pharmacy Coverage; you will pay 30% coinsurance plus the difference between our Plan allowance and the billed amount at an out-of-network retail pharmacy. There is no out-of-network mail order pharmacy program. Your HRA must be used to help you satisfy your deductible. Note: 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 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 10 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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There are important features you should be aware of 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 1-800/537-9384 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/fed to review our Formulary Guide or call 1-800/537-9384.
- **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 do have to file a claim.** Send your itemized bill(s) to: Aetna, Pharmacy Management, Claim Processing, P.O. Box 398106, Minneapolis, MN 55439-8106.

Benefit Description	You pay
<p>Covered medications and supplies</p> <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 or from an out-of-network retail pharmacy:</p> <ul style="list-style-type: none"> • Drugs and medicines 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 • Insulin • Disposable needles and syringes for the administration of covered medications 	<p>In-network:</p> <p>The full cost of the prescription is applied to the deductible before any benefits are considered for payment under the pharmacy plan. Once the deductible is satisfied, the following will apply:</p> <p>Retail Pharmacy, for up to a 30-day supply per prescription or refill:</p> <p>\$10 per covered generic formulary drug; \$25 per covered brand name formulary drug; and \$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 \$50 per covered brand name formulary drug; and \$80 per covered non-formulary (generic or brand name) drug.</p> <p>Out-of-network (retail pharmacies only):</p> <p>30% plus the difference between our Plan allowance and the billed amount.</p>

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>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 Medication Formulary Guide, call 1-800/537-9384. 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/fed for current Medication Formulary Guide information. 	<p>In-network:</p> <p>50%</p> <p>\$25/kit</p> <p>\$25 copay per vial</p> <p>\$25 per diaphragm</p> <p>Out-of-network (retail pharmacies only):</p> <p>30% plus the difference between our Plan allowance and the billed amount, except for drugs to treat sexual dysfunction which are 50% plus the difference between our Plan allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs used for the purpose of weight reduction, such as appetite suppressants</i> • <i>Drugs for cosmetic purposes, such as 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 6.3(g) Special features

Feature	Description
<p>Aetna IntelliHealth®</p>	<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/fed.</p>
<p>Aetna Navigator™</p>	<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/fed.</p>
<p>Informed Health® Line</p>	<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>
<p>Services for the deaf and hearing-impaired</p>	<p>1-800/628-3323</p>

Section 6.4 Catastrophic protection for out-of-pocket expenses

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.

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

Self Only: Your annual out-of-pocket maximum is \$4,000.

Self and Family: Your annual out-of-pocket maximum is \$8,000.

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

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

Section 6.5 Health education resources and account management tools

Special features	Description
<p>Health education resources</p>	<p>We keep you informed on a variety of issues related to your good health. Visit our Web site at www.aetna.com/fed or call Member Services at 1-800/537-9384 for information on:</p> <ul style="list-style-type: none"> • My Aetna Navigator™ • Aetna IntelliHealth website • Healthwise® Knowledge base • Informed Health® Line • Price-A-DrugSM tool • Hospital comparison tool • Price-A-Medical Procedure tool • DocFind online provider directory • Simple Steps to a Healthier Lifestyle
<p>Account management tools</p>	<p>For each HSA and HRA account holder, we maintain a complete claims payment history online through My Aetna Navigator. You can access Navigator at www.aetna.com/fed.</p> <ul style="list-style-type: none"> • Your balance will also be shown on your explanation of benefits (EOB) form. • You will receive an EOB after every claim. • If you have an HSA, <ul style="list-style-type: none"> ✓ You will receive a monthly statement from Aetna outlining your account balance and activity for the month. <p>You may also access your account on-line at by going to My Aetna Navigator at www.aetna.com/fed.</p> <p>If you have an HRA,</p> <ul style="list-style-type: none"> ✓ Your HRA balance will be available online through www.aetna.com/fed ✓ Your balance will also be shown on your EOB form.
<p>Consumer choice information</p>	<ul style="list-style-type: none"> • As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a network provider. Directories are available online by going to Aetna Navigator at www.aetna.com/fed • Pricing information for medical care is available at www.aetna.com/fed • Pricing information for prescription drugs is available at www.aetna.com/fed • Link to online pharmacy through www.aetna.com/fed • Educational materials on the topics of HSAs, HRAs and HDHPs are available at www.aetna.com/fed
<p>Care support</p>	<ul style="list-style-type: none"> • Patient safety information is available online at www.aetna.com

Section 7. 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 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;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 8. 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 1-800/537-9384.

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 1-800/537-9384.

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 1-800/537-9384 or by logging onto your personalized home page on Aetna Navigator from the www.aetna.com/fed 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; and
- 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:

Consumer Directed Health Plan (CDHP)/Health Reimbursement Arrangement (HRA)

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

High Deductible Health Plan (HDHP)/Health Savings Account (HSA)

Aetna Life Insurance Company
P.O. Box 3500
Richmond, KY 40475-3500

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.

You can also call Member Services at 1-800/537-9384.

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

Step	Description
1	<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 Inc., Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512; 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 Street, 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>

Step	Description
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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 1-800/537-9384 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 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, after 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 1-800/537-9384 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 Member Services at 1-800/537-9384.

Section 10. 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 or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has 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 more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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 claim 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 1-800/537-9384 or see our Web site at www.aetna.com/fed.

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

Medicare premium reimbursement – Medicare participating annuitants in the HRA option of the HDHP may request reimbursement for Medicare premiums paid if Health Fund dollars are available. Please contact us at 1-800/537-9384 for more information.

{Primary Payer chart is 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) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
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) and you are not covered under FEHB through your spouse under #1 above	✓	
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) and you are not covered under FEHB through your spouse under #1 above	✓	
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		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

- **Medicare Advantage**

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

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

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the 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 Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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.

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 illness 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 motorist 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 11. 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 19.
Consumer Driven Health Plan	A network provider plan under the FEHB that offers you greater control over choices of your health care expenditures.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 19.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Any type of care provided according to Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; or c) is a level such that you have reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Custodial care includes any type of care where the primary purpose is to attend to your daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples include assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of noninfected wounds, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by you, the general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in our sole determination, is based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, or convalescent care. Custodial care that lasts 90 days or more is sometimes known as long term care. Custodial care is not covered.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.
Dental Fund (Consumer Driven Health Plan)	Your Dental Fund 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: <ul style="list-style-type: none">• There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or• Required FDA approval has not been granted for marketing; or

- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or
- The written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or
- It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or
- It is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or
- It is provided or performed in special settings for research purposes

Health Savings Account (HSA)

An HSA is a special, tax-advantaged account where money goes in tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for qualified health care services.

Health Reimbursement Arrangement (HRA)

An HRA combines a Fund with a deductible-based medical plan with coinsurance limits. The HRA Fund pays first. Once you exhaust your HRA Fund, Traditional Medical Coverage begins after you satisfy your deductible.

High Deductible Health Plan (HDHP)

An HDHP is a plan with a deductible of at least \$1,050 for individuals and \$2,100 for families for 2005, adjusted each year for cost of living.

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 (Consumer Driven Health Plan)

Your Medical Fund is an established benefit amount which is available for you to use to first pay for covered hospital, medical and pharmacy expenses. All your claims will initially be deducted from your Medical Fund. Once the Fund is exhausted, you will need to meet your deductible. Once your deductible is satisfied, Traditional Medical Coverage begins.

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.
- 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 for covered services.

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.

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.

Rollover

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

Us/We

Us and we refer to Aetna Life Insurance Company.

You

You refers to the enrollee and each covered family member.

Section 12. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

See www.opm.gov/insure/health for enrollment as well as:

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

Also, your employing or retirement office can answer your questions, and give you 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 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 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 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 2005 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 2004 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 provide 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 Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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 at 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 information about Federal and State agencies you can contact for more information.

Section 13. Two Federal Programs complement FEHB benefits

Important information

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

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 FSAFEDS:

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 of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. Note: The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. Note: The IRS limits contributions to a DCFSA. 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 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit www.FSAFEDS.com and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877/FSAFEDS (372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800/952-0450.

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 is 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 FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

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 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 20 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this plan, typical out-of-pocket expenses include copayments and/or coinsurance for pharmacy and 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 HCFSA. 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>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits 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 be less. 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 the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and 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 HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is Federal income tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA 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 shown above, 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 an HCFSA is also exempt from FICA taxes. This exemption 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 Forms and Literature page 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?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, 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, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877/FSAFEDS (1-877/372-3337)
- TTY: 1-800/952-0450

The Federal Long Term Care Insurance Program

- **It's important protection** Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care 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 options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of 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 future change in your 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. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **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 - 2005 Consumer Driven Health Plan (CDHP) Option

- **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.
- For the Consumer Driven Health Plan (CDHP), your health charges are applied to your Medical Fund, \$1,000 for Self Only and \$2,000 for Self and Family. Once your Medical Fund has been exhausted, you must satisfy your deductible of \$1,000 for Self Only and \$2,000 for Self and Family. 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
<ul style="list-style-type: none"> • In-network medical and dental preventive care 	Nothing at a network provider	21
Medical Fund Account..... <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. 	Nothing up to \$1,000 for Self Only or \$2,000 for Self and Family	26
Dental Fund Account	Nothing up to \$300 for Self Only or \$600 for Self and Family	27
Traditional Medical Coverage after Medical Fund 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.	45

Summary of benefits – continued on next page.

Summary of benefits for Aetna HealthFund – 2005 (continued)
Consumer Driven Health Plan (CDHP) Option

Benefits	You pay	Page
Prescription drugs After your 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 (available in-network only) 	In-network: 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 Out-of-network (retail pharmacy only): 40% plus the difference between our Plan allowance and the billed amount.	46
Special features: Aetna IntelliHealth, Aetna Navigator, Informed Health Line, and services for the deaf and hearing-impaired	Contact Plan	49
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$3,000/Self Only or \$6,000/Self and Family enrollment per year. Some costs do not count toward this protection.	20

Summary of benefits for Aetna HealthFund - 2005 High Deductible Health Plan (HDHP) Option

- **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.
- In 2005, for each month you are eligible for the HSA, Aetna will deposit \$104.16 per month for Self Only enrollment or \$208.33 per month for Self and Family enrollment to your HSA.
- For the Health Savings Account (HSA), you must satisfy your deductible of \$2,500 for Self Only and \$5,000 for Self and Family by using your HSA or using other funds. Once you satisfy your deductible, Traditional Medical Coverage begins.
- For the Health Reimbursement Arrangement (HRA), your health charges are applied to your HRA Fund of \$1,250 for Self Only and \$2,500 for Self and Family. Once your HRA is exhausted, you must satisfy your deductible. Once your deductible is satisfied, Traditional Medical Coverage begins.

Benefits	HSA You pay	HRA You pay	Page
<ul style="list-style-type: none"> • In-network medical and dental preventive care 	Nothing at a network provider	Nothing at a network provider	66
Health Savings Account (HSA) <ul style="list-style-type: none"> • Up to \$1,250 for Self Only or \$2,500 for Self and Family for medical, surgical, hospital, mental health and substance abuse services and prescription drugs. 	Plan contributes \$1,250 for Self Only and \$2,500 for Self and Family for the HSA. For the HSA, you may voluntarily contribute up to \$1,250 for Self Only and \$2,500 for Self and Family.		55
Health Reimbursement Arrangement (HRA)..... <ul style="list-style-type: none"> • Up to \$1,250 for Self Only or \$2,500 for Self and Family for medical, surgical, hospital, mental health and substance abuse services and prescription drugs. 		Plan pays \$1,250 for Self Only and \$2,500 for Self and Family.	58
Traditional Medical Coverage after HRA Fund is exhausted and after the deductible has been satisfied. For the HSA, Traditional Medical Coverage 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: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	69

Summary of benefits – continued on next page.

Summary of benefits for Aetna HealthFund – 2005 (continued)
High Deductible Health Plan (HDHP) Option

Benefits	HSA You pay	HRA You pay	Page
Emergency benefits.....	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	84
Mental health and substance abuse treatment.....	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	85
Prescription drugs After HRA has been exhausted and your deductible has been satisfied, your copay will apply. For the HSA, after your deductible has been satisfied, your copay will apply. <ul style="list-style-type: none"> • Plan pharmacy • Mail order (available in-network only) 	In-network: 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 Out-of-network (retail pharmacy only): 30% plus the difference between our Plan allowance and the billed amount.	In-network: 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 Out-of-network (retail pharmacy only): 30% plus the difference between our Plan allowance and the billed amount.	86

Summary of benefits – continued on next page.

Summary of benefits for Aetna HealthFund – 2005 (continued)
High Deductible Health Plan (HDHP) Option

Benefits	HSA You pay	HRA You pay	Page
Special features: Aetna IntelliHealth, Aetna Navigator, Informed Health Line, and services for the deaf and hearing-impaired	Contact Plan	Contact Plan	89
Health education resources and account management tools: health education resources, account management tools, consumer choice information, and care support.....	Contact Plan	Contact Plan	91
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$4,000/Self Only or \$8,000/Self and Family enrollment per year. Some costs do not count toward this protection. Your deductible counts toward your out-of-pocket maximum.	Nothing after \$4,000/Self Only or \$8,000/Self and Family enrollment per year. Some costs do not count toward this protection. Your deductible counts toward your out-of-pocket maximum.	20, 90

Notes

2005 Rate Information for Aetna HealthFund

Non-Postal rates apply to most non-Postal employees. 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	<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Consumer Driven Health Plan (CDHP) Self Only	221	\$102.60	\$ 34.20	\$222.30	\$ 74.10	\$121.41	\$ 15.39
Consumer Driven Health Plan (CDHP) Self and Family	222	\$235.99	\$ 78.66	\$511.31	\$170.43	\$279.25	\$ 35.40
High Deductible Health Plan (HDHP) Self Only	224	\$115.30	\$ 38.43	\$249.81	\$ 83.27	\$136.44	\$ 17.29
High Deductible Health Plan (HDHP) Self and Family	225	\$265.19	\$ 88.40	\$574.58	\$191.53	\$313.81	\$ 39.78