Aetna Open Access®

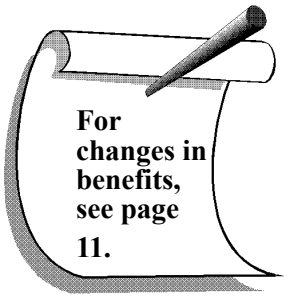
http://www.aetnafeds.com

2009

A Health Maintenance Organization (high and basic option)

Serving: All of Washington, D.C., Northern/Central/Southern Maryland, Northern/Central/Richmond, Virginia Area, and Charlotte and Raleigh/ Durham, North Carolina areas.

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See pages 9-10 for requirements.



1/16/2011
Aetna Health Inc. (Maryland)
10/27/09
Aetna of the Carolinas, Inc.

These Plans have Excellent Accreditation from NCQA.
See the *2009 Guide to Federal Benefits* for more information on accreditation.

Enrollment code for this Plan:

JN1 High Option - Self Only
JN2 High Option - Self and Family
JN4 Basic Option - Self Only
JN5 Basic Option - Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

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

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Important Notice from Aetna About
Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800/772-1213 (TTY 1-800/325-0778).

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

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the Aetna* benefits under our contract (CS 1766) 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
Federal Plans
PO Box 550
Blue Bell, PA 19422-0550

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 benefits that were available before January 1, 2009 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 11. Rates are shown at the end of this brochure.

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

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 fehbwebcomments@opm.gov. You may also write to OPM at the U.S. 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 Program premium.

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

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

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

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- 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.**

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

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 reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.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/. 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 this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory or visit our Web site at www.aetnafeds.com. We give you a choice of enrollment in a High Option or Basic Option.

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

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

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

General features of our High and Basic Options

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

We have Open Access benefits

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments, coinsurance, or deductible.

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

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

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

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

Your rights

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.

Your medical and claims records are confidential

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

Medical Necessity

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

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

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

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

Mental Health/Substance Abuse

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

Ongoing Reviews

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

Authorization

Certain services and supplies under this Plan may require authorization by us to determine if they are covered benefits under this Plan.

Patient Management

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

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

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

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

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

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

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

Member Services

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

- Ask questions about benefits and coverage.

- Notify us of changes in your name, address or telephone number.
- Change your primary care physician or office.
- Obtain information about how to file a grievance or an appeal.

Privacy Notice

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to your physical or mental health or condition, the provision of health care to you, or payment for the provision of health care to you. 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 you.

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 your consent. However, we recognize that you may not want to receive unsolicited marketing materials unrelated to your health benefits. We do not disclose personal information for these marketing purposes unless you consent. We also have policies addressing circumstances in which you are unable to give consent.

To obtain a hard copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please write to Aetna's Legal Support Services Department at 151 Farmington Avenue, W121, Hartford, CT 06156. You can also visit us at www.aetnafeds.com. You can link directly to the Notice of Privacy Practices by selecting the "Privacy Notices" link.

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 Aetna, Federal Plans, PO Box 550, Blue Bell, PA 19422-0550. You may also contact us by fax at 215/775-5246 or visit our Web site at www.aetnafeds.com.

Service Area

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

All of Washington, DC.

In **Maryland**, the counties of Anne Arundel, Baltimore, Baltimore City, Calvert, Carroll, Cecil, Charles, Frederick, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, St. Mary's, Talbot, Washington and Wicomico.

In **North Carolina, Charlotte and Raleigh/Durham areas**, and the counties of Anson, Cabarrus, Cleveland, Durham, Gaston, Iredell, Lincoln, Mecklenburg, Orange, Rowan, Union and Wake.

In **Virginia**, the counties of Amelia, Arlington, Caroline, Charles City, Charlotte, Chesterfield, Cumberland, Dinwiddie, Fairfax, Fauquier, Goochland, Hanover, Henrico, King George, King William, Loudoun, Louisa, Lunenburg, New Kent, Nottoway, Powhatan, Prince Edward, Prince George, Prince William, Spotsylvania, Stafford, Surry, Sussex and Westmoreland; plus the cities of Alexandria, Colonial Heights, Fairfax, Falls Church, Fredericksburg, Hopewell, Manassas, Manassas Park, Petersburg and Richmond, and portions of the following county as defined by the towns listed below:

Buckingham: Arvonia, Buckingham, Dillwyn and New Canton.

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

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

Section 2. How we change for 2009

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

Changes to both High and Basic Options

- Your share of the non-Postal premium under both High and Basic Options will increase for Self Only and increase for Self and Family See page 86.
- Under "Home Health Services," private duty nursing is now excluded and skilled nursing services are limited to three (3) visits per day, with each visit being four (4) hours or less, and subject to a member coinsurance of 20% of our Plan allowance. See pages 30-31.
- Under "Dental benefits," we no longer list in the brochure the discounted fees for the various covered dental procedures. As specific fees vary by area of the country, and specific negotiated rates vary by dentist, members now must call Member Services at 1-800/537-9384 for specific fees for your procedure, or for the specific negotiated rates for your procedure. See pages 53-57.
- We have expanded our Service Area to include the state of North Carolina. It includes the cities of Charlotte, Raleigh/Durham, and the entire counties of Anson, Cabarrus, Cleveland, Durham, Gaston, Iredell, Lincoln, Mecklenburg, Orange, Rowan, Union and Wake. See page 9.

Section 3. How you get care

Open Access HMO

This Open Access Plan is available to our members in those FEHBP service areas identified starting on page 9. You can go directly to any network specialist for covered services without a referral from your primary care physician. Whether your covered services are provided by your selected primary care physician (for your PCP copay) or by another participating provider in the network (for the specialist copay), you will be responsible for payment which may be in the form of a copay (flat dollar amount) or coinsurance (a percentage of covered expenses). While not required, it is highly recommended that you still select a PCP and notify Member Services of your selection (1-800/537-9384**). If you do not select a PCP, and you self-refer to a participating PCP for care, the specialist copay will apply. If you go directly to a specialist, you are responsible for verifying that the specialist is participating in our Plan. If your participating specialist refers you to another provider, you are responsible for verifying that the other specialist is participating in our Plan.**

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800/537-9384 or write to us at Aetna, P.O. Box 14089, Lexington, KY 40512-4089. You may also request replacement cards through our Navigator Web site at www.aetnafeds.com.

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

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

- **Primary care**

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

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us or visit our Web site. We will help you select a new one.

- **Specialty care**

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

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

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

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

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

- **Hospital care**

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 1-800/537-9384. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

- You are discharged, not merely moved to an alternative care center; 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.

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

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain 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 artificial insemination you must contact the Infertility Case Manager at 1-800/575-5999;
- You must obtain precertification from your primary care doctor and Aetna for covered follow-up care with non-participating providers.

Your Plan physician must obtain approval for certain services such as hospitalization and the following services:

- For surgical treatment of morbid obesity (bariatric surgery);
- For select outpatient surgery;
- For air ambulance;
- For surgical correction of congenital defects, such as cleft lip and cleft palate;
- Reconstructive procedures that may be considered cosmetic;
- Surgery used to treat obstructive sleep apnea by enlarging the oropharynx such as uvulopalatopharyngoplasty;
- For home IV and antibiotic therapy;
- For limb and torso prosthetics;
- For orthognathic surgery and TMJ surgery;
- For inpatient confinements, skilled nursing facilities, rehabilitation facilities, and inpatient hospice;
- Residential treatment center, and partial hospitalization programs;
- Intensive outpatient treatment programs, including outpatient detoxification, and outpatient electroconvulsive therapy;
- Psychological and neuropsychological testing;
- Biofeedback, amytal interview, and hypnosis;
- For covered transplant surgery;
- When full-time skilled nursing care is necessary in an extended care facility;
- For non-emergent ambulance transportation service;
- For certain injectable drugs before they can be prescribed;
- For growth hormone therapy treatment;
- For intravenous immunoglobulin (IVIG) therapy treatment;
- For penile implants;
- For all home health care services; and
- For certain outpatient imaging studies such as CT scans, MRIs, MRAs and nuclear stress tests.

You or your physician must obtain an approval for certain durable medical equipment. Members must call 1-800/537-9384 for authorization.

Section 4. Your cost for covered services

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

Copayments

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

Example: When you see your primary care physician you pay a copayment of $15 per office visit or $25 when you see a participating specialist under High Option and $20 per office visit to your primary care physician, or $30 when you see a participating specialist under Basic Option.

Cost-sharing

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

Deductible

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

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

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

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

Coinsurance

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

Example: In our Plan, you pay 50% of our allowance for infertility services and drugs to treat sexual dysfunction.

Differences between our Plan allowance and the bill

- Network Providers agree to accept our Plan allowance so if you use a network provider, you never have to worry about paying the difference between our Plan allowance and the billed amount for covered services.
- Non-Network Providers (for Dental PPO Option only): If you use a non-network provider for preventive dental care, you will have to pay 50% of our negotiated rate and the difference between our Plan allowance and the billed amount.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $3,000/Self Only or $6,000/Self and Family enrollment for the High Option and $4,000/Self Only or $8,000/Self and Family enrollment for the Basic Option in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Prescription drugs
- Dental services
- Infertility services

Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.

Carryover

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

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

When Government facilities bill us

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

High and Basic Option Benefits

See page 11 for how our benefits changed this year. Page 84 and page 85 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Basic Option Benefits Overview

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

The High and Basic Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High and Basic Option benefits, contact us at 1-800/537-9384 or at our Web site at www.aetnafeds.com.

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

- You can see participating network specialists without a referral (Open Access).
- You have more choices for your dental coverage. You can choose between our Basic Dental or Dental PPO option. Under Basic Dental, you can access preventive care for a $5 copay and other services at a reduced fee. Under the PPO option, if you see an in-network dentist, you pay nothing for preventive care after a $20 annual deductible per member. You pay reduced fees for other services when utilizing network dentists. You may also utilize non-network dentists for preventive care, but at reduced benefit levels, and after a $20 annual deductible per member. You pay all charges for other services when utilizing non-network dentists.
- You receive a $100 reimbursement every 24 months for glasses or contact lenses.
- You can use Aetna Health Connections Disease Management Programs which are available for thirty-four conditions.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- If you live or work in an Open Access HMO service area, you should select a PCP by calling Member Services at 1-800/537-9384. **If you do not select a PCP and you self-refer to a participating PCP for care, you will pay a specialist copay.**
- If you live or work in an Aetna Open Access HMO service area, you do not have to obtain a referral from your PCP to see a network specialist.

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Basic Option**
Professional services of physicians • In physician's office - Office medical consultations - Second surgical or medical opinion - Initial examination of a newborn child covered under a family enrollment • During a hospital stay • In a skilled nursing facility	$15 per primary care physician (PCP) visit $25 per specialist visit	$20 per primary care physician (PCP) visit $30 per specialist visit
Professional services of physicians • In an urgent care center	$50 per visit	$50 per visit
• At home	$20 per PCP visit $25 per specialist visit	$25 per PCP visit $30 per specialist visit
• At home visits by nurses and health aides	Nothing	Nothing
Lab, X-ray and other diagnostic tests	**High Option**	**Basic Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound	Nothing if you receive these services during your office visit; otherwise, $15 per PCP visit, $25 per specialist visit	Nothing if you receive these services during your office visit; otherwise, $20 per PCP visit, $30 per specialist visit

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

Benefit Description	You pay	
Lab, X-ray and other diagnostic tests (cont.)	**High Option**	**Basic Option**
• Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $15 per PCP visit, $25 per specialist visit	Nothing if you receive these services during your office visit; otherwise, $20 per PCP visit, $30 per specialist visit
Preventive care, adult	**High Option**	**Basic Option**
Routine screenings, such as: • Urinalysis • Total Blood Cholesterol • Fasting lipid profile • Routine Prostate Specific Antigen (PSA) test — one annually for men age 50 and older and men age 40 and over who are at increased risk for prostate cancer • Digital rectal examination (DRE) – one annually for men aged 40 to 75 • Colorectal Cancer Screening, including - 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 ten years starting at age 50 • Chlamydia screening – one annually • Human papillomavirus (HPV) screening covered when done in combination with a Pap test for women ages 30 and older • Abdominal Aortic Aneurysm Screening – Ultrasonography, one screening for men between the age of 65 and 75 with a smoking history Note: For some of these screenings, you may pay either a specialist copay or an outpatient hospital copay depending on where the procedure is performed.	Nothing if you receive these services during your office visit; otherwise, $15 per PCP visit, $25 per specialist visit; $175 in ambulatory surgical center or in an outpatient department of a hospital	Nothing if you receive these services during your office visit; otherwise, $20 per PCP visit, $30 per specialist visit; 10% of our Plan allowance in ambulatory surgical center or in an outpatient department of a hospital
• Routine well-woman exam, including Pap test, one visit every 12 months from last date of service Note: No copay for the Pap test if performed on the same day as the office visit. Routine physicals - One exam every 24 months up to age 65 - One exam every 12 months age 65 or older	$15 per PCP visit $25 per specialist visit	$20 per PCP visit $30 per specialist visit

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**High Option**	**Basic Option**
Routine mammogram — covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 and older, one every calendar year; or when medically necessary Routine Osteoporosis Screening • For women 65 and older • At age 60 for women at increased risk	$25 per specialist visit	$30 per specialist visit
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Tetanus, Diptheria and Pertussis (Tdap) vaccine for those 19 to 64 years of age, with a booster once every 10 years. For 65 and above, a tetanus-diphtheria booster is still recommended every 10 years. • Influenza vaccine, annually • Varicella (chicken pox) vaccine for all persons age 19 to 49 years without evidence of immunity to varicella • Pneumococcal vaccine, age 65 and older • Human papillomavirus (HPV) vaccine for women age 18 through age 26 • Herpes Zoster (Shingles) vaccine for all persons age 60 and older	Nothing if provided during the office visit	Nothing if provided during the office visit
Not covered: • *Physical exams, immunizations, and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.*	*All charges*	*All charges*
Preventive care, children	**High Option**	**Basic Option**
Childhood immunizations recommended by the American Academy of Pediatrics: • Hepatitis A vaccine – for all infants age 12-23 months • Tetanus, Diphtheria and Pertussis (Tdap) vaccine – for children age 11-12 years or for children age 13-18 years who did not previously receive the vaccination. • Rotavirus vaccine for infants age 8-32 weeks • Screening examination of premature infants for Retinopathy of Prematurity – A retinal screening exam performed by an ophthalmologist for infants with low birth weight (<1500g) or gestational age of 32 weeks or less and infants weighing between 1500 and 2000g or gestational age of more than 32 weeks with an unstable clinical course.	Nothing	Nothing

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**High Option**	**Basic Option**
• Meningococcal vaccine for children at risk as indicated by the American Academy of Pediatrics • Human papilloma virus (HPV) vaccine for girls age 9 to age 22 • Hearing loss screening of newborns provided by a participating hospital before discharge	Nothing	Nothing
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing per PCP visit through age 17; $15 per PCP visit for ages 18 to 22 $25 per specialist visit	Nothing per PCP visit through age 17; $20 per PCP visit for ages 18 to 22 $30 per specialist visit
Not covered: • *Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.*	*All charges*	*All charges*
Maternity care	**High Option**	**Basic Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • 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 extend your inpatient stay if medically necessary , but you, your representative, your participating doctor, or your hospital must precertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. 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.	$15 for the first PCP visit only or $25 for the first specialist visit only Note: If your PCP or specialist refers you to another provider or facility for additional services, you pay the applicable copay for the service rendered.	$20 for the first PCP visit only or $30 for the first specialist visit only Note: If your PCP or specialist refers you to another provider or facility for additional services, you pay the applicable copay for the service rendered.

Maternity care - continued on next page

Benefit Description	You pay	
Maternity care (cont.)	**High Option**	**Basic Option**
• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). Note: Also see our Maternity Management Program (Aetna's Beginning Right℠ Maternity Program) in Section 5 (h).	$15 for the first PCP visit only or $25 for the first specialist visit only Note: If your PCP or specialist refers you to another provider or facility for additional services, you pay the applicable copay for the service rendered.	$20 for the first PCP visit only or $30 for the first specialist visit only Note: If your PCP or specialist refers you to another provider or facility for additional services, you pay the applicable copay for the service rendered.
Not covered: Routine sonograms to determine fetal age, size or sex.	*All charges*	*All charges*
Family planning	**High Option**	**Basic Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs, such as Depo-Provera • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives and Depo-Provera under the prescription drug benefit.	$15 per PCP visit $25 per specialist visit	$20 per PCP visit $30 per specialist visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Basic Option**
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. Diagnosis and treatment of infertility, such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) Note: Coverage is only for 6 cycles (per lifetime). Infertility services must be authorized. You must contact the Infertility Case Manager at 1-800/575-5999. You must use our select network of participating Plan infertility providers. • Fertility drugs	50% of all charges	50% of all charges

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Basic Option**
Note: We cover oral fertility drugs under the prescription drug benefit. In vitro fertilization is a covered benefit when the following criteria are met: • You and your spouse have a history of infertility of at least 2 years duration, • Your oocytes are fertilized with your spouse's sperm, and • Your infertility is associated with endometriosis, exposure in-utero to diethylstilbestrol (DES), blockage of, or surgical removal of, one or both fallopian tubes, or abnormal male factors, including oligospermia contributing to the infertility, and • You have been unable to attain a successful pregnancy through a less costly treatment that is covered by the Plan. Note: In vitro fertilization is limited to three attempts per live birth, a maximum lifetime benefit of $100,000. This includes the cost of fertility drugs. We cover oral fertility drugs under the prescription drug benefit. Injectable fertility drugs are covered only for in vitro fertilization.	50% of all charges	50% of all charges
Not covered: • *Infertility services for couples in which either partner has had a previous sterilization procedure, with or without surgical reversal, and for females who have undergone a hysterectomy.* • *Infertility treatment when the FSH level is 19 mIU/ml or greater on day 3 of menstrual cycle* • *Cost of donor sperm and donor eggs* • *Assisted Reproductive Technology (ART) procedures not shown, such as embryo transfer (frozen), GIFT, ZIFT, sex selection, surrogacy, gene therapy, gestational carriers, cryopreservation, and any other services and supplies related to the non-covered ART procedures* • *Charges associated with care of the donor, such as those required for donor egg retrievals or transfers* • *Charges associated with cryopreservation* • *Charges associated with a gestational carrier program or for the member or the gestational carrier* • *Home ovulation prediction kits*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	**High Option**	**Basic Option**
• *Drugs related to the treatment of non-covered benefits or related to the treatment of infertility that are not medically necessary based on current medical standards; including, but not limited to, GnRH agonists, IVIG; and injectable fertility medications not used with in vitro fertilization* • *Charges associated with a frozen embryo transfer including thawing charges* • *Reversal of voluntary, surgically induced sterility*	*All charges*	*All charges*
Allergy care	**High Option**	**Basic Option**
• Testing and treatment • Allergy injections Note: You pay the applicable copay for each visit to a doctor's office including each visit to a nurse for an injection.	$15 per PCP visit $25 per specialist visit	$20 per PCP visit $30 per specialist visit
Allergy serum	Nothing	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*	*All charges*
Treatment therapies	**High Option**	**Basic Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 36. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy must be precertified by your Plan physician • Growth hormone therapy (GHT) Note: Growth hormone therapy is covered under Medical Benefits; office copay applies. We cover growth hormone injectables under the prescription drug benefit. 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 *Services requiring our prior approval* in Section 3.	$25 per treatment	$30 per treatment

Benefit Description	You pay	
Physical and occupational therapies	**High Option**	**Basic Option**
Twenty visits per condition per member per calendar year for the services of each of the following: • Qualified physical therapists, and • Occupational therapists 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. 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. • Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome	$25 per visit, nothing during a covered inpatient admission	$30 per visit, nothing during a covered inpatient admission
Not covered: Long-term rehabilitative therapy	*All charges*	*All charges*
Pulmonary and cardiac rehabilitation	**High Option**	**Basic Option**
• Twenty visits per condition per member per calendar year of pulmonary rehabilitation to treat functional pulmonary disability • Cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or a myocardial infarction is provided for up to 3 visits a week for a total of 18 visits.	$25 per visit, nothing during a covered inpatient admission	$30 per visit, nothing during a covered inpatient admission
Not Covered: Long-term rehabilitative therapy	*All charges*	*All charges*
Habilitative therapy	**High Option**	**Basic Option**
• Habilitative services for children under age 19 with congenital or genetic birth defects including, but not limited to, autism or an autism spectrum disorder, and cerebral palsy. Treatment is provided to enhance the child's ability to function. Services include occupational therapy, physical therapy and speech therapy. Note: No day or visit limit applies.	$25 per visit, nothing during a covered inpatient admission	$30 per visit, nothing during a covered inpatient admission
Speech therapy	**High Option**	**Basic Option**
• Twenty visits per condition per member per calendar year	$25 per visit, nothing during a covered inpatient admission	$30 per visit, nothing during a covered inpatient admission

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies)	**High Option**	**Basic Option**
• Audiological testing and medically necessary treatment for hearing problems • Hearing testing for children through age 17 (See *Preventive care, children*)	$15 per PCP visit $25 per specialist visit	$20 per PCP visit $30 per specialist visit
• For children up to age 18 — hearing aids, testing, fitting and the examination for them Note: Discounts on hearing exams, hearing services, and hearing aids are also available to all members. Please see the Non-FEHB Benefits section of this brochure for more information.	All charges over $1,400/ear / every 36-month period	All charges over $1,400/ear / every 36-month period
Not covered: All other hearing testing not medically necessary	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Basic Option**
• Treatment of eye diseases and injury	$15 per PCP visit $25 per specialist visit	$20 per PCP visit $30 per specialist visit
• Corrective eyeglasses and frames or contact lenses (hard or soft) per 24 month period.	All charges over $100	All charges over $100
• Routine eye refraction based on the following schedule: • If member wears eyeglasses or contact lenses: - Age 1 through 18 — once every 12-month period - Age 19 and over — once every 24-month period • If member does not wear eyeglasses or contact lenses: - Age 1 through 45 — once every 36-month period - Age 46 and over — once every 24-month period Note: See *Preventive Care, Children* for eye exams for children	$25 per specialist visit	$30 per specialist visit
Not covered: • *Fitting of contact lenses* • *Vision therapy, including eye patches and eye excercises, e.g., orthoptics, pleoptics, for the treatment of conditions related to learning disabilities or developmental delays* • *Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors*	*All charges*	*All charges*

Benefit Description	You pay	
Foot care	**High Option**	**Basic Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$15 per PCP visit $25 per specialist visit	$20 per PCP visit $30 per specialist visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open manipulation or fixation)* • *Foot orthotics* • *Podiatric shoe inserts*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Basic Option**
• Orthopedic devices such as braces and prosthetic devices such as artificial limbs and eyes. Limb and torso prosthetics must be preauthorized. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, penile implants, defibrillator, surgically implanted breast implant following mastectomy, and lenses following cataract removal. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.) Note: Coverage includes repair and replacement when due to growth or normal wear and tear.	Nothing	Nothing
• Hair prosthesis for hair loss resulting from radiation therapy or chemotherapy	Nothing up to Plan lifetime maximum of $500; all charges over $500	Nothing up to Plan lifetime maximum of $500; all charges over $500
Not covered: • *Orthopedic and corrective shoes not attached to a covered brace* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports*	*All charges*	*All charges*

Benefit Description	You pay	
Durable medical equipment (DME)	**High Option**	**Basic Option**
We cover rental or purchase of durable medical equipment , at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds (Clinitron and electric beds must be preauthorized); • Wheelchairs (motorized wheelchairs and scooters must be preauthorized); • Crutches; • Walkers; and • Insulin pumps and related supplies such as needles and catheters. Note: You must get your DME from a participating DME provider. Some DME may require precertification by you or your physician	Nothing	Nothing
Not covered: • *Elastic stockings and support hose* • *Bathroom equipment such as bathtub seats, benches, rails and lifts* • *Home modifications such as stairglides, elevators and wheelchair ramps* • *Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities*	*All charges*	*All charges*
Home health services	**High Option**	**Basic Option**
• Home health services ordered by a Plan Physician and provided by nurses and home health aides through a participating home health care agency. Home health services include skilled nursing services provided by a licensed nursing professional; services provided by a physical therapist, occupational therapist, or speech therapist; and services of a home health aide when provided in support of the skilled home health services. Home health services are limited to 3 visits per day with each visit equal to a period of 4 hours or less. Your Plan Physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications. Note: Short-term physical, speech, or occupational therapy accumulate toward the applicable benefit limit (See physical speech and occupational therapy benefit in this section).	20% of our Plan allowance	20% of our Plan allowance

Home health services - continued on next page

Benefit Description	You pay	
Home health services (cont.)	**High Option**	**Basic Option**
Note: Home health services must be precertified by your Plan physician.	20% of our Plan allowance	20% of our Plan allowance
Not covered: • *Nursing care for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative and appropriate for the active treatment of a condition, illness, disease or injury.* • *Services provided by a family member or resident in the member's home.* • *Services rendered at any site other than the member's home.* • *Services rendered when the member is not homebound because of illness or injury.* • *Private duty nursing services.*	*All charges*	*All charges*
Chiropractic	**High Option**	**Basic Option**
Chiropractic services up to 20 visits per member per calendar year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electric muscle stimulation, vibratory therapy and cold pack application	$15 per PCP visit $25 per specialist visit	$20 per PCP visit $30 per specialist visit
Not covered: Any services not listed above	*All Charges*	*All charges*
Alternative treatments	**High Option**	**Basic Option**
No benefits.	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Basic Option**
Aetna Health Connections offers disease management for 34 conditions. Included are programs for: • Asthma • Cerebrovascular disease • Congestive heart failure (CHF) • Chronic obstructive pulmonary disease (COPD) • Coronary artery disease • Cystic Fibrosis • Depression disease management • Diabetes • Hepatitis • Inflammatory bowel disease • Kidney failure • Kidney failure with dialysis • Low back pain	Nothing	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay	
Educational classes and programs (cont.)	**High Option**	**Basic Option**
• Sickle Cell disease To request more information on our disease management programs, call 1-800/537-9384.	Nothing	Nothing

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Basic Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (See *Reconstructive surgery*)	$15 per PCP visit $25 per specialist visit Nothing for the surgery	$20 per PCP visit $30 per specialist visit Nothing for the surgery

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Basic Option**
• Surgical treatment of morbid obesity (bariatric surgery) – a condition that has persisted for at least 2 years in which an individual has a body mass index (BMI) exceeding 40 or a BMI greater than 35 in conjunction with documented significant co-morbid conditions (such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea or refractory hypertension). Eligible members must be age 18 or over or have completed full growth. We require member participation in a physician-supervised nutrition and exercise program within the past two years for a cumulative total of 6 months or longer in duration, with participation in one program for at least three consecutive months, prior to the date of surgery documented in the medical record by an attending physician who supervised the member's participation; or member participation in an organized multidisciplinary surgical preparatory regimen of at least three months duration proximate to the time of surgery. For members who have a history of severe psychiatric disturbance or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary. We will consider open or laparoscopic Roux-en-Y gastric bypass or laparoscopic adjustable silicone gastric banding (Lap-Band) procedures. • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Skin grafting and tissue implants	$15 per PCP visit $25 per specialist visit Nothing for the surgery	$20 per PCP visit $30 per specialist visit Nothing for the surgery
Not covered: • *Reversal of voluntary surgically-induced sterilization* • *Surgery primarily for cosmetic purposes* • *Radial keratotomy and laser surgery, including related procedures designed to surgically correct refractive errors*	*All charges*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Basic Option**
• *Routine treatment of conditions of the foot; see Foot care*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Basic Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital and developmental anomalies are: protruding ear deformities; 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: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (*See Prosthetic devices*) • Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Basic Option**
Oral surgical procedures, that are medical in nature, such as: • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ (must be preauthorized); and • Excision of tumors and cysts.	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay	
Oral and maxillofacial surgery (cont.)	**High Option**	**Basic Option**
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.	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery
Not covered: • *Dental implants* • *Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Basic Option**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *National Transplant Program (NTP)* on page 39 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description. • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas; Pancreas/Kidney (simultaneous) • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Basic Option**
- Hemoglobinopathy (i.e., Fanconi's, Thalessemia major) - Myelodysplasia/myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for: - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - De-novo myeloma	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery
Blood or marrow stem cell transplants for: • Allogeneic transplants for: - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer* - Epithelial ovarian cancer*	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Basic Option**
- Ependymoblastoma* - Ewing's sarcoma - Medulloblastoma - Pineoblastoma* - Waldenstrom's macroglobulinemia * Approved clinical trial necessary for coverage	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery
Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery
Tandem transplants (for covered transplants): Subject to medical necessity	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health 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 for: • Allogeneic transplants for: - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/myelodysplastic syndromes - Multiple myeloma - Multiple sclerosis • Nonmyeloablative allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer* - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer* - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Basic Option**
- Multiple sclerosis - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma* - Sarcomas* * Approved clinical trial necessary for coverage • Autologous transplants for: - Chronic lymphocytic leukemia* - Chronic myelogenous leukemia* - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma* - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Small cell lung cancer - Multiple sclerosis* - Systemic lupus erythematosus* - Systemic sclerosis* - Scleroderma-SSc (severe, progressive) * Approved clinical trial necessary for coverage • National Transplant Program (NTP) — Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your primary care doctor and plan specialist physician and approved by our medical director in advance of the surgery. The transplant must be performed at hospitals (Institutes of Excellence) specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program. Note: An accepted donor is covered for evaluations and for medical expenses incurred only during the donation hospitalization.	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Basic Option**
Note: Harvesting of tissue for storage purposes only is not eligible for coverage. If both the donor and the transplant recipient are covered by us, donor expenses are attributed to the transplant recipient's coverage. Aetna does not extend coverage for donor services when the transplant recipient is not our member.	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery
Clinical trials must meet the following criteria: A. The member has a current diagnosis that will most likely cause death within one year or less despite therapy with currently accepted treatment; or the member has a diagnosis of cancer; AND B. *All* of the following criteria must be met: 1. Standard therapies have not been effective in treating the member or would not be medically appropriate; and 2. The risks and benefits of the experimental or investigational technology are reasonable compared to those associated with the member's medical condition and standard therapy based on at least two documents of medical and scientific evidence (as defined below); and 3. The experimental or investigational technology shows promise of being effective as demonstrated by the member's participation in a clinical trial satisfying ALL of the following criteria: a. The experimental or investigational drug, device, procedure, or treatment is under current review by the FDA and has an Investigational New Drug (IND) number; and b. The clinical trial has passed review by a panel of independent medical professionals (evidenced by Aetna's review of the written clinical trial protocols from the requesting institution) approved by Aetna who treat the type of disease involved and has also been approved by an Institutional Review Board (IRB) that will oversee the investigation; and c. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national cooperative body (e.g., Department of Defense, VA Affairs) and conforms to the rigorous independent oversight criteria as defined by the NCI for the performance of clinical trials; and d. The clinical trial is not a single institution or investigator study (NCI designated Cancer Centers are exempt from this requirement); and		

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Basic Option**
4. The member must: a. Not be treated "off protocol," and b. Must actually be enrolled in the trial.	$25 per specialist visit Nothing for the surgery	$30 per specialist visit Nothing for the surgery
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia	**High Option**	**Basic Option**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Note**:** For sedation or anesthesia relating to dental services performed in a dental office, see Section 5 (g), Dental benefits. Note: When the anesthesiologist is the primary giver of services, such as for pain management, the specialist copay applies.	Nothing	Nothing

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **Except in emergencies, all hospital admissions and select outpatient surgery require precertification from your participating physician and prior authorization from Aetna.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Basic Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. • Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, Immunoglobulin, and prolastin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	$150 per day up to a maximum of $450 per admission	10% of our Plan allowance per admission

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Basic Option**
Not covered: • *Whole blood and concentrated red blood cells not replaced by the member* • *Non-covered facilities, such as nursing homes, schools* • *Custodial care, rest cures, domiciliary or convalescent cares* • *Personal comfort items, such as telephone and television* • *Private nursing care*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Basic Option**
• 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 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.	$175 per visit	10% of our Plan allowance per visit
Services not associated with a medical procedure being done the same day, such as: • Mammogram • Radiologic procedures • Lab tests	$25 per specialist visit	$30 per specialist visit
Not covered: Whole blood and concentrated red blood cells not replaced by the member.	*All charges*	*All charges*

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Basic Option**
Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 90-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.	Nothing	Nothing
Not covered: Custodial care	*All charges*	*All charges*
Hospice care	**High Option**	**Basic Option**
Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of a Plan doctor, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less.	Nothing	Nothing
Ambulance	**High Option**	**Basic Option**
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm). 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or 3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member.	Nothing	Nothing
Not covered: • *Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency.* • *Ambulette service*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our Service Area:

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

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

- Call the local emergency hotline (e.g., 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your primary care physician. Notify your primary care physician as soon as possible after receiving treatment.
- After assessing and stabilizing your condition, the emergency facility should contact your primary care physician so he/she can assist the treating physician by supplying information about your medical history.
- If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify your primary care physician or Aetna as soon as possible.

Emergencies outside our Service Area:

If you are traveling outside your Aetna service area or if you are a student who is away at school, you are covered for emergency and urgently needed care. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center or an emergency facility. Certain conditions, such as severe vomiting, earaches, sore throats or fever, are considered "urgent care" outside your Aetna service area and are covered in any of the above settings.

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

Follow-up Care after Emergencies

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

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Basic Option**
• Emergency care at a doctor's office	$15 per PCP visit $25 per specialist visit	$20 per PCP visit $30 per specialist visit
• Emergency care at an urgent care center	$50 per visit	$50 per visit
• Emergency care as an outpatient at a hospital (Emergency Room) , including doctors' services. Note: If you are admitted from the Emergency Room to a hospital, the copay is waived.	$100 per visit	$100 per visit
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Basic Option**
• Emergency care at a doctor's office	$25 per specialist visit	$30 per specialist visit
• Emergency care at an urgent care center	$50 per visit	$50 per visit
• Emergency care as an outpatient at a hospital (Emergency Room), including doctors' services. Note: If you are admitted from the Emergency Room to a hospital, the copay is waived.	$100 per visit	$100 per visit
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges*	*All charges*
Ambulance	**High Option**	**Basic Option**
Aetna covers ground ambulance from the place of injury or illness to the closest facility that can provide appropriate care. The following circumstances would be covered: 1. Transport in a medical emergency (i.e., where the prudent layperson could reasonably believe that an acute medical condition requires immediate care to prevent serious harm). 2. To transport a member from one hospital to another nearby hospital when the first hospital does not have the required services and/or facilities to treat the member; or	Nothing	Nothing

Ambulance - continued on next page

Benefit Description	You pay	
Ambulance (cont.)	**High Option**	**Basic Option**
3. To transport a member from hospital to home, skilled nursing facility or nursing home when the member cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available; or 4. To transport a member from home to hospital for medically necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the member. Air ambulance may be covered. Prior approval is required. Note: See 5(c) for non-emergency service.	Nothing	Nothing
Not covered: • Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency. • Ambulette service • Air ambulance without prior approval	*All charges*	*All charges*

Section 5(e). Mental health and substance abuse benefits

When you receive approved services and follow an approved treatment plan, 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.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below. We may limit your benefits if you do not obtain a treatment plan for inpatient care.

Benefit Description	You pay	
Mental health and substance abuse benefits	**High Option**	**Basic Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management • Diagnostic tests • Psychological and neuropsychological tests	$25 per visit	$30 per visit
• Outpatient services provided by a hospital or other facility • Residential crisis services when rendered by a facility licensed to provide such services • Services in approved alternative care settings such as partial hospitalization, facility based intensive outpatient treatment	$25 per outpatient visit	$30 per outpatient visit
Inpatient services: • Approved residential treatment facility • Hospital service	$150 per day up to a maximum of $450 per admission	10% of our Plan allowance per admission
Not covered: • *Services we have not approved.* • *Out-of-network mental health and substance abuse services*	*All charges*	*All charges*

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	**High Option**	**Basic Option**
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.	*All charges*	*All charges*

Preauthorization	Behavioral health care services (e.g., treatment or care for mental disease or illness, alcohol abuse and/or substance abuse) are managed by Aetna Behavioral Health. Since this is an Aetna Open Access Plan, you do not need referrals. Aetna Behavioral Health can assist in coordinating outpatient referrals even though precertification is only necessary for the following services: • Any intensive outpatient care • Outpatient detoxification • Partial hospitalization • Any inpatient or residential care • Psychological or neuropsychological testing • Outpatient electroconvulsive therapy • Biofeedback, amytal interview, and hypnosis • Psychiatric home health care Aetna can assist you in locating participating providers in the Plan, unless your needs for covered services extend beyond the capability of the affiliated providers. Emergency care is covered (See Section 5(d), Emergency services/accidents). You can receive information regarding the appropriate way to access the behavioral health care services that are covered under your specific plan by calling Member Services at 1-800/537-9384. A referral from your PCP is not necessary to access behavioral health care but your PCP may assist in coordinating your care.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Certain drugs require your doctor to get precertification from the Plan before they can be prescribed under the Plan. Upon approval by the Plan, the prescription is good for the current calendar year or a specified time period, whichever is less.

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

- **Who can write your prescription.** A licensed Plan physician or dentist must write the prescription.
- **Where you can obtain them.** You may fill non-emergency prescriptions at a participating Plan retail pharmacy or by mail order for up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay, and for a 31-day up to a 90-day supply of medication for two copays. In no event will the copay exceed the cost of the prescription drug. Please call Member Services at 1-800/537-9384 for more details on how to use the mail order program. **Mail order is not available for drugs and medications ordered through Aetna Specialty Pharmacy. Prescriptions ordered through Aetna Specialty Pharmacy are only filled for up to a 30-day supply due to the nature of these prescriptions.** In an emergency or urgent care situation, you may fill your covered prescription at any retail pharmacy. For retail pharmacy transactions, you must present your Aetna Member ID card at the point of sale for coverage. If you obtain an emergency prescription at a pharmacy that does not participate with the plan, you will need to pay the pharmacy the full price of the prescription and submit a claim for reimbursement subject to the terms and conditions of the plan.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The Plan's formulary does not exclude medications from coverage, but requires a higher copayment for nonformulary drugs. 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.aetnafeds.com to review our Formulary Guide or call 1-800/537-9384.
- **Drugs not on the formulary.** Aetna has a Pharmacy and Therapeutics Committee, comprised of physicians, pharmacists and other clinicians that review drugs for inclusion in the formulary. They consider the drug's effectiveness, safety and cost in their evaluation. While most of the drugs on the non-formulary list are brand drugs, some generic drugs also may be on the non-formulary list. For example, this may happen when brand medications lose their patent and the FDA has granted a period of exclusivity to specific generic manufacturers. When this occurs, the price of the generic drug may not decrease as you might think most generic drugs do. This period of exclusivity usually ranges between 3-6 months. Once this time period expires, competition from other generic manufacturers will generally occur and this helps lower the price of the drug and this may lead Aetna to re-evaluate the generic for possible inclusion on the formulary. Aetna will place some of these generic drugs that are granted a period of exclusivity on our non-formulary list, which requires the highest copay level. **Remember, a generic equivalent will be dispensed, if available, unless your physician specifically requires a brand name and writes "Dispense as Written" (DAW) on the prescription, so discuss this with your doctor.**
- **Precertification.** Your pharmacy benefits plan includes our precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by our Pharmacy Management Precertification Unit before they will be covered. Only your physician or pharmacist, in the case of an antibiotic or analgesic, can request prior authorization for a drug. Step-therapy is another type of precertification under which certain medications will be excluded from coverage unless you try one or more "prerequisite" drug(s) first, or unless a medical exception is obtained. The drugs requiring precertification or step-therapy are subject to change. Visit our Web site at www.aetnafeds.com for the most current information regarding the precertification and step-therapy lists. Ask your physician if the drugs being prescribed for you require precertification or step therapy.
- **These are the dispensing limitations.** Prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy or by mail order may be dispensed for up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay, and a 31-day up to a 90-day supply of medication for two copays. 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.

Prescription drug benefits begin on next page

- **Smoking cessation**. Treatment is limited to two 90-day courses of prescription nicotine replacement therapy per calendar year. This also includes coverage for two office visits to a physician or other health care provider during each 12-month period for the evaluation and treatment of an insured or dependent to assist the person to cease the use of tobacco products; and two office visits to a physician or other health care provider during each 12-month period for the evaluation and management of a course of nicotine replacement therapy. Smoking cessation drugs and medications that can be obtained over-the-counter without a prescription are excluded from coverage.
- 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 refill 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 prescription refill to be covered 23 days after the last filling, 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, and after the exclusivity period expires, 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 14024, Lexington, KY 40512-4024.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Basic Option**
We cover the following medications and supplies prescribed by a licensed physician or dentist and obtained from a Plan pharmacy or through our mail order program: • Drugs approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as *Not covered.* • Oral contraceptive drugs • Insulin • Disposable needles and syringes needed to inject covered prescribed medications • Diabetic supplies limited to lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips • Contraceptive drugs and devices • Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galectosemia and homocystinuria when administered under the direction of a Plan doctor	Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: $5 per covered generic formulary drug; $25 per covered brand name formulary drug; and $50 per covered non-formulary (generic or brand name) drug. Retail Pharmacy or Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $10 (two copays) per covered generic formulary drug; $50 (two copays) per covered brand name formulary drug; and $100 (two copays) per covered non-formulary (generic or brand name) drug.	Retail Pharmacy or Mail Order Pharmacy, for up to a 30-day supply per prescription or refill: $10 per covered generic formulary drug; $25 per covered brand name formulary drug; and $50 per covered non-formulary (generic or brand name) drug. Retail Pharmacy or Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill: $20 (two copays) per covered generic formulary drug; $50 (two copays) per covered brand name formulary drug; and $100 (two copays) per covered non-formulary (generic or brand name) drug.
Limited benefits: • Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits • Oral and Injectable fertility drugs	50%	50%

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Basic Option**
Note: Injectable fertility drugs are covered only for in vitro fertilization. Please refer to Section 5(a), *Medical Services and Supplies, Infertility Services.*	50%	50%
• Depo-Provera is limited to 5 vials per calendar year	$25 copay per vial	$25 copay per vial
• One diaphragm per calendar year	$25 per diaphragm	$25 per diaphragm

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

- A generic equivalent may be dispensed if it is available, and where allowed by law.
- Certain self-injectable medications, which have been historically covered by HMO members' medical benefits, are now covered under their Aetna Specialty Pharmacy Network prescription drug plan. There are various medical conditions treated with self-injectable medications. Often these drugs require special handling, storage and shipping. In addition, these medications are not always available at retail pharmacies. **The following medical conditions are treated with self-injectable medications that must be obtained through Aetna Specialty Pharmacy Network in order to be eligible for coverage, unless noted otherwise on the list of medications on our website**: Antiasthmatic-Monocoloral antibodies, Arthritis, Blood Clotting (Factor VII, Factor VIII, Factor IX and Anti-Inhibitor Coagulant Complex), Blood Thinners, Diabetic, Emergency Medications (Epinephrine Kits), Erectile Dysfunction, Growth Hormone (Deficiency and over-Production), Infertility, Migraine, Multiple Sclerosis, Osteoporosis, Psoriasis and Viral Infections/Immune System Enhancers. Please visit our Website, www.aetnafeds.com for the 2009 Pharmacy Managed Self-Injectable (PMSI) list or contact us at 1-800/537-9384 for a copy. Note that the drugs and categories covered are subject to change.
- Coverage for blood modifiers used to treat such medical conditions as cancer and kidney dialysis are not impacted by this coverage. Examples of these medications include Procrit, Epogen, Neupogen and Neulasta. Please contact us at 1-800/537-9384 for more details.
- To request a printed 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 www.aetnafeds.com for current Medication Formulary Guide information.

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Basic Option**
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug)* • *Drugs obtained at a non-Plan pharmacy except when related to out-of-area emergency care* • *Vitamins, nutritional and dietary substances/supplements that can be purchased without prescription.* • *Medical supplies such as dressings and antiseptics* • *Lost, stolen or damaged drugs* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Over-the-counter smoking cessation drugs and medications* • *Drugs used for the purpose of weight reduction (i.e., appetite suppressants)* • *Prophylactic drugs including, but not limited to, anti-malarials for travel*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

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

Note: You will be covered automatically under this Basic Dental option unless you enroll in the Dental PPO option by calling Member Services at 1-800/537-9384.

- Under the Dental PPO option, the Plan covers 100% of the charges (after satisfaction of a $20 annual deductible per member) for those preventive, diagnostic, and restorative procedures shown on the next page when using a participating network dentist. Members can take advantage of our network discounts on other dental procedures when using participating network dentists for those services. Members are responsible only for the PPO negotiated rate Aetna has contracted with the participating PPO provider.

You also have the choice to use non-network dentists under this Dental PPO option for those preventive, diagnostic and restorative procedures shown on the next page, but the Plan will cover only 50% of the standard negotiated rate we would have paid an in-network PPO provider. You are responsible for any difference between the amount billed and the amount paid by the Plan for the eligible services listed in this section, plus your annual $20 deductible. **Any other dental services rendered by non-network dentists are not covered.**

- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described on the next pages.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Dental benefits	You Pay
Accidental injury benefit	
No benefits other than those listed on the following schedule.	

Dental benefits begin on next page

Dental benefits	You Pay		
Service	**Basic Dental**	**PPO-Network**	**PPO-Non-Network**
Annual Deductible	No deductible	$20 per member per year.	$20 per member per year.
Diagnostic	No deductible:	Nothing	50% of our negotiated rate and any difference between our allowance and the billed amount.
Office visit for routine oral evaluation — limited to 2 visits per year	$5 per visit		
Bitewing x-rays — limited to 2 sets of bitewing x-rays per year			
Complete x-ray series — limited to 1 complete x-ray series in any 3 year period			
Periapical x-rays and other dental x-rays — as necessary			
Diagnostic casts			
Preventive			
Prophylaxis (cleaning of teeth) — limited to 2 treatments per year			
Topical application of fluoride — limited to 2 courses of treatment per year to children under age 18			
Oral hygiene instruction (not covered under PPO)			
Restorative (Fillings)			
Amalgam 1 surface, primary or permanent			
Amalgam 2 surfaces, primary or permanent			
Amalgam 3 surfaces, primary or permanent			
Amalgam 4 or more surfaces, primary or permanent			
Prosthodontics Removable			
Denture adjustments (complete or partial/upper or lower)			
Endodontics			
Pulp cap — direct			
Pulp cap — indirect			
Note: Members can take advantage of our network discounts on other dental procedures when using participating network dentists for services.			

Dental benefits - continued on next page

Dental benefits (cont.)

Basic Dental Option

Note: Basic Dental option services shown in this section are only covered when provided by your selected participating primary care dentist in accordance with the terms of your Plan. ***If rendered by a participating specialist, they are provided at reduced fees. Pediatric dentists are considered specialists.*** Certain other services will be provided by your selected participating primary care dentist at reduced fees. Specific fees vary by area of the country. Call Member Services at 1-800/537-9384 for specific fees for your procedure. All member fees must be paid directly to the participating dentist. **Services provided by a non-network dentist are not covered.**

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

Each employee and dependent ***must*** select a primary care dentist from the directory when participating in the Basic Dental option and include the dentist's name on the enrollment form. You also may call Member Services at 1-800/537-9384.

Dental PPO

Under this option, you have the choice to use our participating Dental PPO network dentists or a non-network dentist. The benefit levels are different, based on whether or not the dentist participates in our network. You must contact Member Services at 1-800/537-9384 to select this option.

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

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

Dental PPO In-Network Option

The plan covers 100% of the charges (after satisfaction of the $20 annual deductible per member) for those preventive, diagnostic, and restorative procedures shown **on the previous page** when using a participating network dentist. Members can take advantage of our network discounts on other dental procedures when using participating network dentists for services. Please call Member Services at 1-800/537-9384 for specific fees for your procedure.

Dental PPO Non-Network Option

Dentists' normal fees generally are higher than Aetna's negotiated fees. **Non-participating dentists will be paid only for those services shown on the previous page.** Payment will be based on the standard negotiated rate provided to participating general dentists in the same geographic area. Members may be balance billed by the dentist for the difference between the dentist's usual fee and the amount paid by the Plan. **The services on the following pages rendered by non-participating dentists are not covered.**

Dental benefits - continued on next page

Dental benefits Discounted Fee	You Pay up to a maximum fee of		
Dental benefits	**Basic Dental**	**PPO-Network**	**PPO-Non-Network**
Preventive Sealant-per permanent tooth Space maintainer **Restorative (Fillings)** Resin-based composite (anterior) 1 surface Resin-based composite (anterior) 2 surfaces Resin-based composite (anterior) 3 surfaces Resin-based composite (anterior) 4 or more surfaces or incisal angle Metallic inlay **Prosthodontics, removable** Complete denture (upper or lower) Immediate denture (upper or lower) Partial denture resin base (upper or lower) Partial denture cast metal framework with resin base (upper or lower) Denture repairs Add tooth to existing partial Add clasp to existing partial Denture rebase Denture relines Interim denture (complete or partial/upper or lower) Tissue conditioning **Prosthodontics, fixed** Bridge pontic Metallic inlay/onlay Cast metal retainer for resin bonded prosthesis Crown porcelain/ceramic Crown cast metal Recement bridge Post and core **Oral surgery** Extractions, per tooth (surgical, soft tissue, and bony impacted teeth) Deep sedation/general anesthesia (in office, first 30 minutes; above 30 minutes, anesthesia is subject to an additional charge at the discounted rate) Note: For oral and maxillofacial services such as temporomandibular joint (TMJ) surgery, please refer to Section 5(b), Oral and Maxillofacial surgery. **Periodontics (Gum treatment)** Gingivectomy or gingivoplasty, per quadrant Osseous surgery, per quadrant Provisional splinting Periodontal scaling and root planing per quadrant Periodontal maintenance procedure	Specific fees vary by area of the country. Call Member Services at 1-800/537-9384 for specific fees for your procedure.	The participating network dentist's negotiated rate. Specific negotiated rates vary by dentist. Call Member Services at 1-800/537-9384 for specific negotiated rates for your procedure.	*All charges*

Dental benefits - continued on next page

Dental benefits Discounted Fee	You Pay up to a maximum fee of		
Dental benefits (cont.)	**Basic Dental**	**PPO-Network**	**PPO-Non-Network**
Endodontics (Root canal) Therapeutic pulpotomy Root canal therapy (anterior, bicuspid, molar) excluding final restoration Apicoectomy/periradicular surgery-anterior, bicuspid and molar **Orthodontics** Pre-orthodontic treatment visit Comprehensive orthodontic treatment fully banded case (adult age 19 and over) Comprehensive orthodontic treatment fully banded case (child age 18 and under)	Specific fees vary by area of the country. Call Member Services at 1-800/537-9384 for specific fees for your procedure.	The participating network dentist's negotiated rate. Specific negotiated rates vary by dentist. Call Member Services at 1-800/537-9384 for specific negotiated rates for your procedure.	*All charges*
Not covered: • *Dental implants* • *Under the Basic Dental option, services rendered by a nonparticipating dental provider.* • *Under the Dental PPO option, services rendered by a nonparticipating dental provider, unless otherwise noted.* • *Flouride gel carriers* • *We offer no other dental benefits than those shown in this section.*	*All charges*	*All charges*	*All charges*

Section 5(h). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Aetna Navigator	Aetna Navigator, our secure member self service website, provides you with the tools and personalized information to help you manage your health. Click on My Navigator from www.aetnafeds.com to register and access a secure, personalized view of your Aetna benefits. With Aetna Navigator, you can: • Review eligibility and PCP selections • Print temporary ID cards • Download details about a claim such as the amount paid and the member's responsibility • Contact member services at your convenience through secure messages • Access cost and quality information through Aetna's transparency tools • View and update your Personal Health Record • Find information about the member extras that come with your plan • Access health information through Aetna Intelihealth and Healthwise® Knowledgebase Registration assistance is available toll free, Monday through Friday, from 7am to 9pm Eastern Time at 1-800/225-3375. Register today at www.aetnafeds.com.
Services for deaf and hearing-impaired	1-800/628-3323

Special features-continued on next page

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.
Maternity Management Program	Aetna's Beginning Right℠ Maternity Management Program provides services, information and resources to help improve pregnancy outcomes. Features of the program include a pregnancy risk survey, obstetrical nurse care coordination, comprehensive educational information on prenatal care, labor and delivery, newborn and baby care, a smoking-cessation program, and more. To enroll in the program, call toll-free 1-800/CRADLE-1.
National Medical Excellence Program	National Medical Excellence Program helps eligible members access appropriate, covered treatment for solid organ and tissue transplants using our Institutes of Excellence™ network. We coordinate specialized treatment needed by members with certain rare or complicated conditions and assist members who are admitted to a hospital for emergency medical care when they are traveling temporarily outside of the United States. Services under this program must be preauthorized.
Reciprocity benefit	If you need to visit a participating primary care physician for a covered service, and you are 50 miles or more away from home you may visit a primary care physician from our plan's approved network. • Call 1-800/537-9384 for provider information and location • Select a doctor from 3 primary care doctors in that area • The Plan will authorize you for one visit and any tests or X-rays ordered by that primary care physician • You must coordinate all subsequent visits through your own participating primary care physician

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at, 1-800/537-9384 or visit their website at www.aetnafeds.com

Aetna InteliHealth®

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 InteliHealth to provide trusted and credible health information to its users. Aetna InteliHealth features include: a Drug Resource Center, Disease and Condition Management tools, Health Risk Assessments, the Harvard Symptom Scout (an interactive symptom checker that provides guidance about a variety of symptoms), Daily Health News and much more. Visit InteliHealth at www.aetnafeds.com.

Aetna Vision SM Discounts

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 Aetna Vision Discounts Program with more than 13,000 providers 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. If your health plan also includes coverage for eyewear such as prescription eyeglasses or contact lenses, your out-of-pocket expense can be reduced when you use Aetna Vision discount. You may purchase your eyewear at Aetna Vision locations at discounted rates, and your allowance will automatically be applied at point of purchase. You don't have to submit the receipt for reimbursement. Your allowance applies to prescription eyeglasses or contact lenses only.

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

Hearing Discounts

The Hearing discount program helps you and your family (including parents and grandparents) save on hearing exams, hearing services and hearing aids. This program is offered in conjunction with HearPO® and includes access to over 1,500 participating locations. HearPO provides discounts on hearing exams, hearing services, hearing aid repairs, and choice of the latest technologies. Call HearPO customer service at 1-888-432-7464. Make sure the HearPO customer service representative knows you are an Aetna member. HearPO will send you a validation packet and you will receive the discounts at the point of purchase.

Fitness Program

Aetna offers members access to discounted fitness services provided by GlobalFit™.The 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.

Natural Products and Services Program

The Natural Products and Services program provides alternative choices to members who want to explore new products in the area of alternative medicine. Additionally, the program helps members save on nontraditional services they may already use. With the Natural Products and Serices Program, you are eligible to receive discounts from participating professionals on chiropractic manipulation, acupuncture, massage and nutritional counseling. You can also save on the purchase of vitamins, herbal and nutritional supplements, and on health-related products such as aromatherapy. For more information, please call Aetna Member Services at 1-800/537-9384.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless 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 14** (see specifics regarding transplants).

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (*See Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Procedures, services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies 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 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians 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 for services you receive outside the Plan's service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your medical, hospital and vision claims to: Aetna, P.O. Box 14089, Lexington, KY 40512-4089.

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

Submit your pharmacy claims to: Aetna, Pharmacy Management, Claim Processing, P.O. Box 14024, Lexington, KY 40512-4024.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

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

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Aetna, Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask 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	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

The disputed claims process *(cont.)*

Step	Description
	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.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary 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, the primary plan will pay for the expenses first, up to its plan limit. If the expense is covered in full by the primary plan, we will not pay anything. If the expense is not covered in full by the primary plan, we will determine our allowance. We will not pay more than our allowance. For example, we will generally only make up the difference between the primary payer's benefit payment and 100% of our Plan allowance, subject to our applicable deductible, if any, and coinsurance or copayment amounts, except when Medicare is the primary payer. When Medicare is the primary payer and the provider accepts Medicare assignment, our allowance will be Medicare's allowance. Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

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; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800/772-1213 (TTY 1-800/325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **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 more Parts of Medicare, you can still be covered under the FEHB Program.

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

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

If you 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.

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.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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

When we are the primary 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. To find out if you need to do something to file your claim, call us at 1-800/537-9384.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800/MEDICARE (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. Please call us at 1-888/788-0390. **We do not waive cost-sharing for your FEHB coverage.**

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), 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.

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

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. For more information, please call us at 1-800/832-2640. See ***Important Notice from Aetna about our Prescription Drug Coverage and Medicare*** on the first inside page of this brochure for information on Medicare Part D.

Medicare always makes the final determination as to whether they are the primary 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

- You 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 injuries or illness for which another party may be responsible, 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," "Any Party" or "Responsible Party" 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.

You specifically acknowledge our right of subrogation. When we provide health care benefits for injuries or illnesses for which another responsible party is or may be responsible, we shall be subrogated to your rights of recovery against any responsible 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 responsible 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 another party is or may be responsible and you and/or your representative has recovered any amounts from the responsible party or any party making payments on the responsible 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 responsible 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 another 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 responsible party to the extent of the full cost of all benefits provided by us associated with injuries or illnesses for which another 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 another party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement and regardless of whether each payment will result in a recovery to the Member which is insufficient to make the Member whole or to compensate the Member in part or in whole for the damages sustained), 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; and
- Serve as a constructive trustee for the benefit of this Plan or any settlement or recovery funds received as a result of Third Party injuries.

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 Aetna's recovery, and Aetna is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by the Member to pursue the Member's claim or lawsuit against any Responsible Party without the prior express written consent of Aetna. 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.

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

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

Recovery rights related to Workers' Compensation

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

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

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

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

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

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

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

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

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

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

Section 10. Definitions of terms we use in this brochure

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

Coinsurance — Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.

Copayment — A copayment is a fixed amount of money you pay when you receive covered services. See page 15.

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

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

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

Deductible — A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 15.

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

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

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

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

Medical necessity

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

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

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

Open Access HMO

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

Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for the service or supply in the geographic area where it is furnished. Plans determine their allowances in different ways. We determine our allowance as follows: We may take into account factors such as the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility, and the prevailing charge in other areas in determining the Plan allowance for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.
Precertification	Precertification is the process of collecting information prior to inpatient admissions and performance of selected ambulatory procedures and services. The process permits advance eligibility verification, determination of coverage, and communication with the physician and/or you. It also allows Aetna to coordinate your transition from the inpatient setting to the next level of care (discharge planning), or to register you for specialized programs like disease management, case management, or our prenatal program. In some instances, precertification is used to inform physicians, members and other health care providers about cost-effective programs and alternative therapies and treatments. Certain health care services, such as hospitalization or outpatient surgery, require precertification with Aetna to ensure coverage for those services.
Preventive care	Health care services designed for prevention and early detection of illnesses in average risk people, generally including routine physical examinations, tests and immunizations.
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.
Us/We	Us and We refer to Aetna.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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 information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who 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 Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; 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 2009 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 2008 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.

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

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits 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 Benefits 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 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care or health care expenses. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** –Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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. 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. You must apply to know if you will be approved for enrollment. To request an Information Kit and 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 the High Option of the Aetna Open Access Plan - 2009

- **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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $25 specialist	20
Services provided by a hospital:		
• **Inpatient**	$150 per day up to a maximum of $450 per admission	42
• **Outpatient**	$175 per visit	43
Emergency benefits:		
• **In-area**	$100 per visit	46
• **Out-of-area**	$100 per visit	46
Mental health and substance abuse treatment:	Regular cost sharing	48
Prescription drugs: You may fill non-emergency prescriptions at a participating Plan retail pharmacy or by mail order for up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay, and a 31-day up to a 90-day supply of medication for two copays. In no event will the copay exceed the cost of the prescription drug.	For up to a 30-day supply: $5 per generic formulary; $25 per brand name formulary; and $50 per nonformulary (generic or brand name). For a 31-day up to a 90-day supply: Two copays	51
Dental care:	Various copays, coinsurance, reduced fees or deductibles	53-57
Vision care:	$25 copay per visit. All charges over $100 for eyeglasses or contacts per 24 month period	28
Special features: Flexible benefits option, Aetna Navigator, Services for the deaf and hearing-impaired, Informed Health Line, Maternity Management Program, National Medical Excellence Program, and Reciprocity benefit.	Contact Plan	58-59
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $3,000/Self Only or $6,000/ Family enrollment per year. Some costs do not count toward this protection.	15

Summary of benefits for the Basic Option of the Aetna Open Access Plan - 2009

- **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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Basic Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $30 specialist	20
Services provided by a hospital:		
• Inpatient	10% of our Plan allowance per admission	42
• Outpatient	10% of our Plan allowance per visit	43
Emergency benefits:		
• In-area	$100 per visit	46
• Out-of-area	$100 per visit	46
Mental health and substance abuse treatment:	Regular cost sharing	48
Prescription drugs: You may fill non-emergency prescriptions at a participating Plan retail pharmacy or by mail order for up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay, and a 31-day up to a 90-day supply of medication for two copays. In no event will the copay exceed the cost of the prescription drug.	For up to a 30-day supply: $10 per generic formulary; $25 per brand name formulary; and $50 per nonformulary (generic or brand name). For a 31-day up to a 90-day supply: Two copays	51
Dental care:	Various copays, coinsurance, reduced fees or deductibles	53-57
Vision care:	$30 copay per visit. All charges over $100 for eyeglasses or contacts per 24 month period	28
Special features: Flexible benefits option, Aetna Navigator, Services for the deaf and hearing-impaired, Informed Health Line, Maternity Management Program, National Medical Excellence Program, and Reciprocity benefit.	Contact Plan	58-59
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4,000/Self Only or $8,000/ Family enrollment per year. Some costs do not count toward this protection.	15

2009 Rate Information for the Aetna Open Access Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* 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 *Guide to Benefits for Career United States Postal Service Employees,* RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 *Guide to Federal Benefits.*

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	JN1	$155.66	$106.18	$337.26	$230.06	$179.45	$82.39
High Option Self and Family	JN2	$352.56	$233.93	$763.88	$506.85	$406.42	$180.07
Basic Option Self Only	JN4	$128.90	$42.96	$279.27	$93.09	$148.66	$23.20
Basic Option Self and Family	JN5	$301.64	$100.54	$653.54	$217.85	$347.89	$54.29