

Aetna HealthFund®

<http://www.aetnafeds.com>



2008

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

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

Underwritten and administered by: Aetna Life Insurance Company

Enrollment in this Plan is limited: You must live or work in our Geographic service area to enroll. See pages 11-14 for requirements.



★
Utilization Management

3/08

Aetna Life Insurance Company

Enrollment codes for this Plan:

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

RI 73-828

**Important Notice from Aetna About
Our Prescription Drug Coverage and Medicare**

OPM has determined that Aetna HealthFund 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 benefits you can receive of Aetna Life Insurance Company under our contract (CS 2900) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the Aetna* administrative office is:

Aetna Life Insurance Company
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, 2008 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefits are effective January 1, 2008, and changes are summarized on pages 15-16. Rates are shown at the end of this brochure.

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

Plain Language

All FEHB brochures are written in plain language to make them 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.
- 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 e-mail OPM at fehwebcomments@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:

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

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-800/537-9384 and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

**OR WRITE TO: United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100**

- 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); o
 - 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 the 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 reaction to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/consumer/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 the Consumer Driven Health Plan (CDHP) and High Deductible Health Plan (HDHP)

This Plan is an individual practice plan offering you a choice of a Consumer Driven Health Plan (CDHP) or a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. CDHPs deliver the best of both worlds by blending traditional health coverage with a unique Fund benefit to help you pay for covered expenses. HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans.

General features of our Consumer Driven Health Plan(CDHP)

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

For 2008, CDHP offers 100% in-network preventive care coverage, including dental. You have:

- A consumer-controlled annual Medical Fund of \$1,250/Self Only or \$2,500/Self and Family and an annual Dental Fund of \$300/Self Only or \$600/Self and Family to help you pay for eligible expenses. You use your annual Medical Fund first for covered medical expenses, then you need to satisfy your annual member responsibility. Medical Fund dollars that have been rolled over from prior years will apply towards your annual member responsibility. Once your member responsibility has been satisfied, the Traditional Medical Plan benefits will apply. This stretches your Fund dollars as it allows you to use any excess Medical Fund dollars that may have accumulated in prior years to satisfy your annual member responsibility and any coinsurance amounts you are responsible for up to your out-of-pocket maximum. You may also use any excess Medical Fund dollars to pay pharmacy copayments.
- Online tools to help you manage your money and your health.
- Freedom to choose the providers you wish to see – with no referrals.
- A cap that limits the total amount you pay annually for eligible expenses.

Preventive care services for your CDHP

Covered preventive medical and dental care services are paid at 100% if you use a network provider.

Member responsibility for your CDHP

Once you have exhausted your annual medical fund, the annual member responsibility (\$750 for Self Only and \$1,500 for Self and Family) must be met before Traditional Medical Plan benefits are paid for care other than preventive care services. If you are enrolled in the CDHP, rolled over Medical Fund dollars from prior years will help you reduce your member responsibility.

Catastrophic protection for your CDHP

We protect you against out-of-pocket expenses for covered services. Your out-of-pocket expenses for covered services, including member responsibility and copayments, cannot exceed \$3,000 for Self Only enrollment or \$6,000 for Self and Family enrollment for in-network services or \$4,000 for Self Only enrollment or \$8,000 for Self and Family enrollment for out-of-network services.

General features of our High Deductible Health Plan (HDHP)

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

- An HSA in which the Plan will automatically deposit \$62.50 per month/Self Only or \$125 per month/Self and Family.
- The ability to make voluntary contributions to your HSA of up to \$2,150/Self Only or \$4,300/Self and Family per year. If you are age 55 or older, you may also make a catch-up contribution of up to \$900 for 2008.

You may consider:

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

The type and extent of covered services, and the amount we allow, may be different from other plans. Read our brochure carefully to understand the benefits and features of this HDHP. The IRS Web site at <http://www.treas.gov/offices/public-affairs/hsa/faq.shtml> has additional information about HDHPs.

Preventive care services for your HDHP

Covered preventive medical and dental care services are paid at 100% if you use in-network providers.

Annual deductible for your HDHP

The annual deductible of \$1,500 for Self Only, \$3,000 for Self & Family in-network and \$2,500 for Self Only, \$5,000 for Self & Family out-of-network, must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA) under HDHP

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

- You may use the money in your HSA to pay all or a portion of your annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified health expense.
- Distributions from your HSA are tax-free for qualified expenses for you, your spouse, and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 10% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the Plan will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. In addition, your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA) under HDHP

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

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

Catastrophic protection for your HDHP

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments, cannot exceed \$4,000 for Self Only enrollment, or \$8,000 for Self and Family enrollment for in-network services or \$5,000 for Self Only enrollment or \$10,000 for Self and Family enrollment when you utilize out-of-network services.

Health education resources and accounts management tools

We have online, interactive health and benefits information tools to help you make more informed health decisions (see page 112).

We have Network Providers

Our network providers offer services through our Plan. When you use our network providers, you will receive covered services at reduced costs. In-network benefits apply only when you use a network provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. Aetna is solely responsible for the selection of network providers in your area. You can access network providers on DocFind by visiting our Web site at www.aetnafeds.com, or contact us for a directory or the names of network providers by calling 1-800/537-9384.

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

How we pay providers

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

Network Providers

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

Non-Network Providers

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

Your rights

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

Your medical and claims records are confidential

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

Medical Necessity

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

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

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

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

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

Ongoing Reviews

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

Authorization

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

Patient Management

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

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

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

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

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

- **Concurrent Review** The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require Concurrent Review.
- **Discharge Planning** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by you upon discharge from an inpatient stay.

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

Member Services

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

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

Privacy Notice

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 our Internet site at www.aetnafeds.com. You can link directly to the Notice of Privacy Practices by selecting the “Privacy Notices” link at the bottom of the page.

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 network providers practice. The enrollment code for all service areas is 22. Our Service Areas are:

Alabama, Most of Alabama (as well as part of Jackson/Vicksburg, MS and Memphis, TN networks) – Autauga, Baldwin, Bibb, Blount, Bullock, Calhoun, Chambers, Cherokee, Chilton, Choctaw, Clarke, Clay, Cleburne, Coffee, Colbert, Coosa, Covington, Crenshaw, Cullman, Dale, Dallas, De Kalb, Elmore, Escambia, Etowah, Fayette, Franklin, Geneva, Hale, Henry, Houston, Jackson, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Limestone, Lowndes, Macon, Madison, Marion, Marshall, Mobile, Monroe, Montgomery, Morgan, Perry, Pickens, Russell, St. Clair, Shelby, Sumter, Talladega, Tallapoosa, Tuscaloosa, Walker, Washington, Wilcox and Winston counties.

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

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

Arkansas, Little Rock, Central, Northwest and Northeast (as well as part of Memphis, TN network) – Arkansas, Baxter, Benton, Boone, Carroll, Clark, Cleburne, Columbia, Conway, Craighead, Crawford, Crittenden, Cross, Faulkner, Franklin, Garland, Grant, Hot Spring, Independence, Jackson, Jefferson, Johnson, Lawrence, Lee, Lincoln, Logan, Lonoke, Madison, Marion, Mississippi, Monroe, Montgomery, Ouachita, Perry, Phillips, Poinsett, Polk, Pope, Prairie, Pulaski, Saline, Scott, Sebastian, Sharp, St. Francis, Stone, Washington, White, Woodruff and Yell counties.

California, Central Valley, Los Angeles, Northern California and San Diego – Alameda, Amador, Butte, Contra Costa, El Dorado, Fresno, Kern, Kings, Los Angeles, Madera, Marin, Merced, Monterey, Napa, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Sutter, Tulare, Tuolumne, Ventura, Yolo and Yuba counties.

Colorado – All of Colorado.

Connecticut – All of Connecticut.

Delaware – All of Delaware.

District of Columbia – All of Washington, DC.

Florida, Daytona Beach, Ft. Myers, Gainesville, Jacksonville, Miami, Ocala, Orlando, Palm Beach, Panama City, Panhandle, Tallahassee and Tampa – Alachua, Baker, Bay, Bradford, Brevard, Broward, Charlotte, Clay, Collier, Columbia, Duval, Escambia, Flagler, Gadsden, Gilchrist, Hernando, Hillsborough, Holmes, Indian River, Jefferson, Lake, Lee, Leon, Levy, Manatee, Marion, Martin, Miami-Dade, Nassau, Okaloosa, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, St. Lucie, Santa Rosa, Sarasota, Seminole, St. Johns, Sumter, Suwannee, Union, Volusia, Wakulla, Walton and Washington counties.

Georgia, Atlanta, Augusta, Macon and Savannah (as well as part of Chattanooga, TN and Greenville/Spartanburg, SC network) – Appling, Baldwin, Banks, Barrow, Bartow, Bibb, Bryan, Bulloch, Burke, Butts, Candler, Carroll, Catoosa, Chatham, Chattooga, Cherokee, Clarke, Clayton, Cobb, Columbia, Coweta, Crawford, Dade, Dawson, DeKalb, Douglas, Effingham, Evans, Fayette, Floyd, Forsyth, Fulton, Glascock, Gordon, Gwinnett, Hall, Haralson, Hart, Henry, Houston, Jackson, Jasper, Jefferson, Jones, Lamar, Laurens, Liberty, Lincoln, Long, Madison, McDuffie, Monroe, Newton, Oconee, Oglethorpe, Paulding, Peach, Pickens, Pike, Polk, Pulaski, Rabun, Richmond, Rockdale, Spalding, Taliaferro, Tattall, Twiggs, Walker, Walton, Warren, Washington and Wilkes counties.

Idaho (part of East Washington (Spokane) network) – Kootenai county.

Illinois, Chicago and Northern IL (as well as part of Indianapolis, IN and St. Louis, MO networks) – Alexander, Bond, Boone, Calhoun, Champaign, Clark, Clinton, Cook, De Kalb, DuPage, Edgar, Fayette, Ford, Fulton, Greene, Grundy, Iroquois, Jersey, Johnson, Kane, Kankakee, Kendall, Knox, La Salle, Lake, Lee, Macoupin, Madison, Marshall, McHenry, Monroe, Ogle, Peoria, Pulaski, Randolph, St. Clair, Scott, Tazewell, Vermilion, Will, Winnebago and Woodford counties.

Indiana, Evansville, Fort Wayne and Indianapolis (as well as part of, Chicago, IL, Louisville, KY and Cincinnati, OH networks) – Adams, Allen, Benton, Blackford, Boone, Brown, Carroll, Cass, Clark, Clay, Clinton, De Kalb, Dearborn, Decatur, Delaware, Floyd, Fountain, Franklin, Gibson, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jay, Jefferson, Johnson, Knox, Kosciusko, Lagrange, Lake, Lawrence, Madison, Marion, Miami, Monroe, Montgomery, Morgan, Noble, Ohio, Owen, Parke, Pike, Porter, Posey, Putnam, Randolph, Ripley, Rush, Scott, Shelby, Steuben, Sullivan, Switzerland, Tippecanoe, Tipton, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Warrick, Washington, Wells, White and Whitley counties.

Kansas, Kansas City (as well as part of Joplin, MO and Northeast OK networks) – Allen, Anderson, Atchison, Cherokee, Chautauqua, Douglas, Franklin, Johnson, Leavenworth, Miami, Montgomery and Wyandotte counties.

Kentucky, Eastern KY, Lexington and Louisville (as well as part of Central OH, Cincinnati, OH, Evansville, IN and Memphis, TN networks) – Anderson, Bell, Boone, Bourbon, Boyd, Breathitt, Breckinridge, Bullitt, Campbell, Carroll, Carter, Clark, Elliott, Estill, Fayette, Floyd, Franklin, Fulton, Gallatin, Grant, Greenup, Hardin, Harlan, Harrison, Henderson, Henry, Jefferson, Jessamine, Johnson, Kenton, Knott, Larue, Lawrence, Letcher, Lewis, Madison, Magoffin, Marion, Mason, Meade, Morgan, Nelson, Oldham, Owen, Pendleton, Perry, Pike, Robertson, Scott, Shelby, Spencer, Trimble, Union, Washington and Woodford counties.

Louisiana, Alexandria, Baton Rouge/Lafayette, Houma/Thibodaux, Lake Charles, New Orleans and Shreveport (as well as part of Jackson/Vicksburg, MS network) – Acadia, Allen, Ascension, Assumption, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, De Soto, East Baton Rouge, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson, Jefferson Davis, Lafayette, Lafourche, Lincoln, Livingston, Madison, Natchitoches, Orleans, Ouachita, Plaquemines, Pointe Coupee, Red River, Richland, Sabine, Saint Bernard, Saint Charles, Saint Helena, Saint James, Saint Landry, Saint Martin, Saint Mary, Saint Tammany, St John The Baptist, Tangipahoa, Terrebonne, Union, Vermilion, Washington, Webster, West Baton Rouge, West Carroll, West Feliciana and Winn parishes.

Maine – All of Maine.

Maryland – All of Maryland.

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

Michigan, Central/Eastern/Northern/Southwest/Western MI and Detroit – Alcona, Alger, Allegan, Alpena, Antrim, Arenac, Baraga, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Cass, Charlevoix, Cheboygan, Chippewa, Clare, Clinton, Crawford, Delta, Dickinson, Eaton, Emmet, Genesee, Gladwin, Gogebic, Grand Traverse, Gratiot, Hillsdale, Houghton, Huron, Ingham, Ionia, Iosco, Iron, Isabella, Jackson, Kalamazoo, Kalkaska, Kent, Keweenaw, Lake, Lapeer, Leelanau, Lenawee, Livingston, Luce, Macomb, Mackinac, Manistee, Marquette, Mason, Mecosta, Menominee, Midland, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Ontonagon, Osceola, Oscoda, Otsego, Ottawa, Presque Isle, Roscommon, Saginaw, St. Clair, St. Joseph, Sanilac, Schoolcraft, Shiawassee, Tuscola, Van Buren, Washtenaw, Wayne and Wexford counties.

Mississippi, Greenville, Gulfport and Jackson/Vicksburg (as well as part of Memphis, TN network) – Adams, Alcorn, Amite, Attala, Benton, Bolivar, Calhoun, Carroll, Chickasaw, Claiborne, Clarke, Coahoma, Copiah, Covington, De Soto, Forrest, George, Grenada, Hancock, Harrison, Hinds, Holmes, Itawamba, Jackson, Jefferson Davis, Jones, Lafayette, Lamar, Lauderdale, Lawrence, Lee, Leflore, Lowndes, Madison, Marion, Marshall, Monroe, Newton, Noxubee, Oktibbeha, Panola, Pearl River, Perry, Pike, Pontotoc, Prentiss, Quitman, Rankin, Scott, Simpson, Stone, Sunflower, Tallahatchie, Tate, Tippah, Tunica, Union, Walthall, Warren, Washington and Webster counties.

Missouri, Columbia/Jefferson City, Joplin, Kansas City, St. Louis and Springfield – Adair, Andrew, Audrain, Barry, Barton, Benton, Boone, Buchanan, Caldwell, Callaway, Camden, Cass, Chariton, Christian, Clark, Clay, Clinton, Cole, Cooper, Crawford, Dade, Dallas, Daviess, De Kalb, Douglas, Franklin, Gasconade, Greene, Grundy, Hickory, Henry, Holt, Howard, Jackson, Jasper, Jefferson, Laclede, Lafayette, Lawrence, Lincoln, Linn, Livingston, Macon, Madison, Maries, McDonald, Miller, Moniteau, Monroe, Montgomery, Morgan, Newton, Osage, Pettis, Phelps, Platte, Polk, Pulaski, Putnam, Randolph, Ray, Saline, Schuyler, Scotland, Shannon, St. Charles, St. Francois, St. Louis, St. Louis City, Ste. Genevieve, Stone, Sullivan, Taney, Texas, Warren, Webster and Wright counties.

Nevada, Las Vegas – Clark and Nye counties.

New Hampshire– All of New Hampshire.

New Jersey – All of New Jersey.

New York, New York City area and Upstate NY – Albany, Bronx, Broome, Cayuga, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Essex, Fulton, Genesee, Greene, Hamilton, Herkimer, Kings, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester and Yates counties.

North Carolina, Central and Western NC, Charlotte, Raleigh/Durham and Winston-Salem – Alamance, Anson, Bladen, Burke, Cabarrus, Caswell, Chatham, Cherokee, Clay, Cleveland, Columbus, Cumberland, Davidson, Davie, Durham, Forsyth, Franklin, Gaston, Graham, Granville, Greene, Guilford, Harnett, Haywood, Hoke, Iredell, Jackson, Johnston, Jones, Lee, Lenoir, Lincoln, Macon, Mecklenburg, Montgomery, Moore, Nash, Orange, Person, Randolph, Richmond, Robeson, Rockingham, Rowan, Rutherford, Sampson, Scotland, Stanly, Stokes, Surry, Swain, Union, Vance, Wake, Warren, Wayne, Wilkes, Wilson and Yadkin counties.

Ohio, Cincinnati, Cleveland, Columbus and Central OH and Toledo – Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Defiance, Delaware, Erie, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Guernsey, Hamilton, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Logan, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Portage, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Union, Van Wert, Vinton, Warren, Washington, Wayne, Williams, Wood and Wyandot counties.

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

Pennsylvania, Central PA, Lehigh Valley, Northeastern PA, Philadelphia and Southeastern PA and Pittsburgh – Adams, Allegheny, Armstrong, Beaver, Berks, Blair, Bradford, Bucks, Butler, Cambria, Carbon, Chester, Clarion, Clinton, Columbia, Cumberland, Dauphin, Delaware, Erie, Fayette, Franklin, Fulton, Greene, Indiana, Jefferson, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, Mercer, Monroe, Montgomery, Northampton, Northumberland, Perry, Philadelphia, Pike, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Washington, Wayne, Westmoreland, Wyoming and York counties.

South Carolina, Columbia, Florence and Greenville/Spartanburg (as well as part of Augusta, GA network and part of Central NC network) – Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Calhoun, Cherokee, Chester, Chesterfield, Darlington, Dillon, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg and York counties.

Tennessee, Chattanooga, Jackson, Knoxville, Memphis, Nashville and Tri-Cities – Anderson, Bedford, Benton, Blount, Bradley, Campbell, Cannon, Carroll, Carter, Cheatham, Chester, Claiborne, Cocke, Coffee, Crockett, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Franklin, Gibson, Giles, Grainger, Greene, Grundy, Hamblen, Hamilton, Hancock, Hardeman, Hawkins, Haywood, Henderson, Houston, Humphreys, Jefferson, Johnson, Knox, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Loudon, Macon, Madison, Marion, Marshall, Maury, McMinn, Meigs, Montgomery, Moore, Morgan, Obion, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Smith, Stewart, Sullivan, Sumner, Tipton, Trousdale, Unicoi, Union, Van Buren, Warren, Washington, Weakley, Williamson and Wilson counties.

Texas, Most of Texas – Aransas, Atascosa, Austin, Bandera, Bastrop, Bee, Bell, Bexar, Blanco, Bosque, Brazoria, Brazos, Brewster, Brooks, Brown, Burlison, Burnet, Caldwell, Calhoun, Cameron, Camp, Carson, Chambers, Cherokee, Clay, Coleman, Collin, Colorado, Comal, Comanche, Cooke, Coryell, Crane, Crockett, Crosby, Culberson, Dallas, De Witt, Deaf Smith, Delta, Denton, Dimmit, Duval, Ector, Edwards, El Paso, Ellis, Erath, Fannin, Fayette, Floyd, Fort Bend, Franklin, Freestone, Frio, Galveston, Gillespie, Goliad, Gonzales, Grayson, Gregg, Grimes, Guadalupe, Hale, Hamilton, Hardeman, Hardin, Harris, Harrison, Hays, Henderson, Hidalgo, Hill, Hockley, Hood, Hopkins, Hudspeth, Hunt, Jackson, Jasper, Jeff Davis, Jefferson, Jim Hogg, Jim Wells, Johnson, Jones, Karnes, Kaufman, Kendall, Kenedy, Kerr, Kimble, Kinney, Kleberg, La Salle, Lamar, Lampasas, Lavaca, Lee, Liberty, Live Oak, Llano, Loving, Lubbock, Madison, Marion, Mason, Matagorda, Maverick, McMullen, Medina, Midland, Milam, Mills, Montague, Montgomery, Morris, Motley, Navarro, Newton, Nueces, Orange, Palo Pinto, Parker, Pecos, Potter, Presidio, Rains, Randall, Reagan, Real, Red River, Reeves, Refugio, Robertson, Rockwall, San Jacinto, San Patricio, San Saba, Smith, Somervell, Starr, Sutton, Tarrant, Taylor, Terrell, Terry, Titus, Tom Green, Travis, Tyler, Upshur, Uvalde, Val Verde, Van Zandt, Victoria, Walker, Waller, Ward, Washington, Webb, Wharton, Wichita, Wilbarger, Willacy, Williamson, Wilson, Winkler, Wise, Wood, Zapata and Zavala counties.

Vermont – Bennington & Windham counties

Virginia, Most of Virginia (as well as part of District of Columbia and Tri-Cities TN networks) – Albemarle, Alleghany, Amelia, Arlington, Bedford, Bland, Botetourt, Bristol, Buchanan, Buckingham, Caroline, Carroll, Charles City, Charlotte, Chesterfield, Clarke, Craig, Culpeper, Cumberland, Dickenson, Dinwiddie, Essex, Fairfax, Fauquier, Floyd, Fluvanna, Franklin, Frederick, Giles, Gloucester, Goochland, Grayson, Hanover, Henrico, Henry, Isle Of Wight, James City, King And Queen, King George, King William, Lancaster, Lee, Loudon, Lunenburg, Mathews, Middlesex, Montgomery, Nelson, New Kent, Northumberland, Nottoway, Patrick, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Radford, Roanoke, Russell, Salem, Scott, Shenandoah, Smyth, Southampton, Spotsylvania, Stafford, Surry, Sussex, Tazewell, Warren, Washington, Westmoreland, Wise, Wythe and York counties, plus the cities of Alexandria, Charlottesville, Chesapeake, Colonial Heights, Covington, Fairfax, Falls Church, Franklin, Fredericksburg, Galax, Hampton, Hopewell, Manassas, Manassas Park, Martinsville, Newport News, Norfolk, Norton, Petersburg, Poquoson, Portsmouth, Richmond, Roanoke, Suffolk, Virginia Beach, Williamsburg and Winchester.

Washington, East WA (Spokane) and Seattle/Puget Sound – Adams, Asotin, Benton, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Franklin, Garfield, Grant, Grays Harbor, Island, Jefferson, King, Kitsap, Kittitas, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Oreille, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whatcom, Whitman and Yakima counties.

West Virginia, Most of West Virginia – Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Greenbrier, Hancock, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pleasants, Preston, Putnam, Raleigh, Ritchie, Roane, Summers, Taylor, Tyler, Upshur, Wayne, Wetzell, Wirt, Wood and Wyoming counties.

Wisconsin, Milwaukee and Southeast – Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Sheboygan, Walworth, Washington and Waukesha counties.

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

Section 2. How we change for 2008

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 this Plan

- United States Postal Service non-law enforcement career employees may now be covered either by Postal Category 1 or Postal Category 2 premium rates. See page 142.

Changes to our Consumer Driven Health Plan (CDHP)

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 142.
- We have increased the Medical Fund to \$1,250 per year for Self Only enrollment and to \$2,500 per year for Self and Family enrollment. See page 32.
- We have decreased the amount of coinsurance you have to pay for In-Network care to 10%. See page 38.
- We have reduced your Member Responsibility (Deductible) to \$750 for Self Only enrollment, and to \$1,500 for Self and Family enrollment. See page 37.

Changes to our High Deductible Health Plan (HDHP)

- Your share of the non-Postal premium will decrease for Self Only and decrease for Self and Family. See page 142.
- We have decreased the premium “pass through” deposit into your Health Savings Accounts (HSA) to \$750 per year (\$62.50 per month) for Self Only enrollment, and to \$1,500 per year (\$125 per month) for Self and Family enrollment. See page 68.
- We have reduced the In-Network calendar year deductible to \$1,500 for Self Only enrollment, and to \$3,000 for Self and Family enrollment. See page 84.
- We have added an Out-of-Network calendar year deductible of \$2,500 for Self Only enrollment, and \$5,000 for Self and Family enrollment. See page 84.

Changes to both our Consumer Driven Health Plan (CDHP) and our High Deductible Health Plan (HDHP)

- We have expanded our Service Area to include the state of Vermont. It includes the entire counties of Bennington and Windham. See page 14.
- We have expanded our existing Service Area in the state of Alabama to include the following: the entire counties of Bullock, Chambers, Crenshaw, Hale, and Macon. See page 11.
- We have expanded our existing Service Area in the state of Alaska to include the following: the entire borough of Skagway Hoonah Angoon. See page 11.
- We have expanded our existing Service Area in the state of Arkansas to include the following: the entire counties of Clark, Lincoln, and Montgomery. See page 11.
- We have expanded our existing Service Area in the state of California to include the following: the entire county of Butte. See page 11.
- We have expanded our existing Service Area in the state of Florida to include the following: the city of Tallahassee and the entire counties of Collier, Gadsden, Jefferson, Leon, and Wakulla. See page 11.
- We have expanded our existing Service Area in the state of Georgia to include the following: the entire counties of Hart, and Rabun, as well as a part of the Greenville/Spartanburg, SC network. See page 11.
- We have expanded our existing Service Area in the state of Illinois to include the following: the entire counties of Alexander, De Kalb, Greene, Johnson, Pulaski, and Scott. See page 11.
- We have expanded our existing Service Area in the state of Indiana to include the following: the entire county of Ripley. See page 12.

- We have expanded our existing Service Area in the state of Louisiana to include the following: the cities of Alexandria, Houma/Thibodaux, and Lake Charles, and the entire parishes of Catahoula, Franklin, Grant, and West Carroll. See page 12.
- We have expanded our existing Service Area in the state of Michigan to include the following: the Southwest part of the state, and the entire counties of Berrien, and Cass. See page 12.
- We have expanded our existing Service Area in the state of Mississippi to include the following: the entire county of Pearl River. See page 12.
- We have expanded our existing Service Area in the state of Missouri to include the following: the entire counties of Andrew, Barry, Benton, Clark, Daviess, Dekalb, Douglas, Hickory, Holt, Laclede, Madison, Schuyler, Shannon, Texas, and Wright. See page 12.
- We have expanded our existing Service Area in the state of North Carolina to include the following: Western NC, and the entire counties of Cherokee, Clay, Graham, Haywood, Hoke, Jackson, Macon, Scotland, and Swain. See page 13.
- We have expanded our existing Service Area in the state of Oklahoma to include the following: the entire county of Okfuskee. See page 13.
- We have expanded our existing Service Area in the state of South Carolina to include the following: the entire counties of Abbeville, Beaufort, McCormick, Oconee, and Saluda. See page 13.
- We have expanded our existing Service Area in the state of Tennessee to include the following: the entire county of Claiborne. See page 13.
- We have expanded our existing Service Area in the state of Texas to include the following: the entire counties of Clay, Hardeman, Tom Green, Wichita, and Wilbarger. See page 14.

Section 3. How you get care

Identification cards

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

- **Network providers**

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

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

- **Network facilities**

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

- **Non-network providers and facilities**

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

What you must do to get covered care

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

- **Transitional care**

Specialty care: If you have a chronic or disabling condition and lose access to your network specialist because we:

- Terminate our contract with your specialist for other than cause; or
- Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Program Plan; or
- Reduce our service area and you enroll in another FEHB plan,

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

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

- **Hospital care**

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

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 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.

How to get approval for...

- **Your hospital stay**

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

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

Warning

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

- **How to precertify an admission**

Certification of days of confinement can be obtained as follows:

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

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

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

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

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

You must obtain approval for certain services such as:

- For air ambulance;
- For surgical treatment of morbid obesity (bariatric surgery);
- For orthognathic surgery and TMJ surgery;
- For surgery to correct 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 select outpatient 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 and air ambulance transportation services;
- For certain injectable drugs before they can be prescribed;
- For growth hormone therapy treatment;
- For intravenous immunoglobulin (IVIG) therapy treatment;
- For penile implants;
- For limb and torso prosthetics;
- For certain outpatient imaging studies, such as CT scans, MRIs and MRAs and nuclear stress tests;
- For certain durable medical equipment;
- For all home health care services; and
- For home intravenous (IV) and antibiotic therapy.

Members must call Member Services at 1-800/537-9384 for authorization.

Section 4. Your cost for covered services

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

Coinsurance	<p>Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible (HDHP) or member responsibility (CDHP).</p> <p>Example: You pay 10% of our Plan allowance for in-network durable medical equipment under both CDHP and HDHP.</p>
Copayments	<p>A copay is the fixed amount of money you pay to the pharmacy when you receive certain services.</p>
Cost-sharing	<p>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.</p>
Deductible	<p>A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them.</p>

High Deductible Health Plan (HDHP)

You must satisfy your deductible before your Traditional medical coverage begins. For the HDHP, your annual deductible is \$1,500 for a Self Only enrollment and \$3,000 for Self and Family enrollment in-network and \$2,500 for a Self Only enrollment and \$5,000 for a Self and Family enrollment out-of-network. The Self and Family deductible can be satisfied by one or more members. The full Family deductible must be met for the plan of benefits to apply. There is no individual limit within the Family deductible.

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

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.

Member Responsibility

Consumer Driven Health Plan (CDHP)

After you have used up your annual Medical Fund of \$1,250 for Self Only or \$2,500 for Self and Family enrollment, you must satisfy your member responsibility. Your member responsibility is \$750 for Self Only or \$1,500 for Self and Family enrollment. The Self and Family member responsibility may be satisfied by one or more family members. Member responsibility limits must be satisfied before the Traditional Medical Plan benefits apply. Any excess Medical Fund dollars that have been rolled over in prior years will also be used to satisfy your member responsibility.

Example:

You have Self Only enrollment and have been in the CDHP for two years and accumulated \$500 in rollover funds. In January, you get a new annual medical fund of \$1,250, bringing your total fund balance to \$1,750.

In February, you have a \$2,000 hospital expense:

- \$1,250 is paid from annual medical fund deposit,
- You are responsible for the next \$750 (member responsibility),
- But since you have \$500 in rollover funds from last year in your medical fund, the fund pays \$500 of your member responsibility and you would be responsible for the remaining \$250 of member responsibility.

- You have now met your member responsibility for the year and any subsequent eligible expenses will be applied towards the Traditional medical coverage.

Note: If you change plans during Open Season, you do not have to start a new deductible or member responsibility 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 or member responsibility under your new plan.

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

Differences between our Plan allowance and the bill

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

Non-Network Providers: If you use a non-network provider, you will have to pay the difference between our Plan allowance and the billed amount.

Your catastrophic protection out-of-pocket maximum

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

CDHP

Only your member responsibility and those out-of-pocket expenses resulting from the application of coinsurance percentage (except any penalty amounts) may be used to satisfy the out-of-pocket maximums. This includes dollars you have paid toward your member responsibility and coinsurance as well as Medical Fund dollars that have paid a portion or all of your member responsibility and/or coinsurance.

Note: For the CDHP, once you have met your member responsibility, and satisfied your out-of-pocket maximums, eligible medical expenses will be covered at 100%.

If you have met your member responsibility the following would apply:

Self Only:

In-network: Your annual out-of-pocket maximum is \$3,000.

Out-of-network: Your annual out-of-pocket maximum is \$4,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is \$6,000.

Out-of-network: Your annual out-of-pocket maximum is \$8,000.

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

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

- Expenses in excess of hospice care maximums

HDHP

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

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

If you have met your deductible, the following would apply:

Self Only:

In-network: Your annual out-of-pocket maximum is \$4,000.

Out of-network: Your annual out-of-pocket maximum is \$5,000.

Self and Family:

In-network: Your annual out-of-pocket maximum is \$8,000.

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

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

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

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.

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.

Section 5. Consumer Driven Health Plan Benefits

See pages 15-16 for how our benefits changed this year and pages 138-139 for a benefits summary.

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Section 5. Consumer Driven Health Plan Benefits Overview

This Plan offers a Consumer Driven Health Plan (CDHP). The CDHP benefit package is described here in this Section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

CDHP Section 5, which describes the CDHP benefits, is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about CDHP benefits, contact us at 1-800/537-9384 or at our Web site at www.aetnafeds.com.

The Aetna HealthFund Consumer Driven Health Plan (CDHP) focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. With this Plan, eligible in-network medical and dental preventive care is covered in full, and you can use the Medical Fund for any covered care. If you use up your annual Medical Fund, the Traditional medical coverage begins after you satisfy your member responsibility. If you don't use up your Medical Fund for the year, you can roll it over to the next year, up to the maximum rollover amount, as long as you continue to be enrolled in the Aetna HealthFund CDHP. Remember, any Medical Fund dollars you have rolled over from previous years in the Plan will help you satisfy your member responsibility.

The Aetna HealthFund CDHP includes these five key components:

- In-Network Medical and Dental Preventive Care**

This component covers 100% for preventive care for adults and children if you use a network provider. The covered medical services include office visits/exams, immunizations and screenings, and the covered dental services include oral evaluations, cleanings, x-rays, fluoride applications, sealants, and space maintainers. These services are fully described in Section 5. The services are based on recommendations by the American Medical Association, the American Academy of Pediatrics, and the American Dental Association. You do not have to meet the member responsibility before using these services.
- Aetna HealthFund (Medical and Dental Funds)**

The Plan provides an annual Medical Fund for each enrollment. For 2008, the Plan provides \$1,250 for a Self Only enrollment or \$2,500 for a Self and Family enrollment. The Medical Fund covers 100% of your eligible medical expenses. The Medical Fund is described in greater detail in Section 5.

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

The Dental Fund covers 100% of your eligible dental expenses. The Dental Fund is described in greater detail in Section 5.

If you have an unused Medical or Dental Fund balance at the end of the calendar year, that balance will rollover so you can use it in the future, as long as you continue to participate in the Plan. If you terminate your participation in the Plan, your Medical and Dental Fund balances are lost.

Note: In-Network Medical and Dental Preventive Care benefits paid under Section 5 do NOT count against your Medical or Dental Funds.
- Traditional medical coverage subject to the member responsibility**

Under Traditional medical coverage, you must first use your annual Medical Fund and then satisfy your member responsibility (\$750 for Self Only enrollment, \$1,500 for Self and Family enrollment). If available, excess Medical Fund dollars rolled over from prior years will be used to satisfy your member responsibility. Once you have satisfied your member responsibility, the Plan generally pays 90% of the cost for in-network care and 60% for out-of-network care. If you still have rollover Medical Fund dollars available once Traditional medical coverage begins, your Medical Fund will cover your coinsurance or pharmacy copayment amounts until exhausted.

Catastrophic protection for out-of-pocket expenses

When you use network providers, your annual maximum for out-of-pocket expenses (member responsibility, coinsurance and copayments) for covered services is limited to \$3,000 for Self Only or \$6,000 for Self and Family enrollment. If you use non-network providers, your out-of-pocket maximum is \$4,000 for Self Only or \$8,000 for Self and Family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and CDHP Section 5 *Traditional medical coverage subject to the member responsibility* for more details.

Health education resources and account management tools

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

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

Aetna Navigator gives you direct access to:

- Personal Health Record that provides you with online access to your personal health information including health care providers, drug prescriptions, medical tests, individual personalized messages, alerts and a detailed health history that can be shared with your physicians.
- The Price-A-Medical ProcedureSM tool to compare network physician fees for select services to typical fees outside the network.
- Estimate the Cost of CareSM that allows you to compare the estimated average costs for 200 different health care services in your area.
- Price-A-Dental ProcedureSM tool to compare network dental fees for select services with typical fees outside the network.
- Price-A-DrugSM tool to estimate the cost of your prescription if obtained at a participating retail or mail order pharmacy.
- A hospital comparison tool that allows you to see how hospitals in your area rank on measures important to your care.
- Our DocFind[®] online provider directory.
- Online customer service that allows you to request member ID cards, send secure messages to Member Services, and more.
- Healthwise[®] Knowledgebase where you get information on thousands of health-related topics to help you make better decisions about your health care and treatment options.

Section 5. In-Network Medical and Dental Preventive Care

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.
- Preventive care is health care services designed for prevention and early detection of illness in average risk, asymptomatic people, generally including routine physical examinations, tests and immunizations.
- The Plan pays 100% for the medical and dental preventive care services listed in this Section as long as you use a network provider.
- If you choose to access preventive care with an out-of-network provider, you will not qualify for 100% preventive care coverage. Please see Section 5 – Medical and Dental Funds, and Section 5 – Traditional medical coverage subject to the member responsibility.
- For preventive care not listed in this Section or preventive care from a non-network provider, please see Section 5 – Medical and Dental Funds.
- For all other covered expenses, please see Section 5 – Medical and Dental Funds and Section 5 – Traditional medical coverage subject to the member responsibility.
- Note that the in-network medical and dental preventive care paid under this Section does NOT count against or use up your Medical or Dental Funds.

Benefit Description	You pay
<p>In-Network Medical Preventive Care, adult</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Blood tests • 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 • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test yearly starting at age 50, - Sigmoidoscopy screening — every five years starting at age 50, - Double contrast barium enema — every five years starting at age 50; - Colonoscopy screening — every 10 years starting at age 50 • Routine annual digital rectal exam (DRE) for men age 40 and older • Abdominal Aortic Aneurysm Screening – ultrasonography, one screening for men between the age of 65 and 75 with a smoking history • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • Human papilloma virus (HPV) screening covered when done in combination with a Pap test for women ages 30 and older 	<p>In-network: Nothing at a network provider.</p> <p>Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your annual Medical Fund are subject to your member responsibility until satisfied and then subject to Traditional medical coverage (see Section 5).</p>

In-Network Medical Preventive Care, adult - continued on next page

Benefit Description	You pay
<p>In-Network Medical Preventive Care, adult (cont.)</p> <ul style="list-style-type: none"> • Routine mammogram — covered for women age 35 and older, as follows: <ul style="list-style-type: none"> - From age 35 through 39, one during this five year period - From age 40 to 64, one every calendar year - At age 64 and older, one every two consecutive calendar years • Routine Osteoporosis Screening <ul style="list-style-type: none"> - For women 65 and older - At age 60 for women at increased risk • Routine physicals: <ul style="list-style-type: none"> • One exam every 24 months up to age 65 • One exam every 12 months age 65 and older • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) such as: <ul style="list-style-type: none"> - Tetanus, Diphtheria 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 over - Human papilloma virus (HPV) vaccine for women age 18 through age 26 - Herpes Zoster (Shingles) vaccine for all persons age 60 and older <p>The following exams limited to:</p> <ul style="list-style-type: none"> • 1 routine eye exam every 12 months • 1 routine OB/GYN exam every 12 months including 1 Pap smear and related services • 1 routine hearing exam every 24 months 	<p>In-network: Nothing at a network provider.</p> <p>Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your annual Medical Fund are subject to your member responsibility until satisfied and then subject to Traditional medical coverage (see Section 5).</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> 	<p><i>All charges</i></p>
<p>In-Network Medical Preventive Care, children</p> <p>Childhood immunizations recommended by the American Academy of Pediatrics:</p> <ul style="list-style-type: none"> • 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 	<p>In-network: Nothing at a network provider.</p> <p>Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your annual Medical Fund are subject to your member responsibility until satisfied and then subject to Traditional medical coverage (see Section 5).</p>

In-Network Medical Preventive Care, children - continued on next page

Benefit Description	You pay
In-Network Medical Preventive Care, children (cont.)	
<ul style="list-style-type: none"> • 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. • Meningococcal vaccine for children at risk as indicated by the American Academy of Pediatrics • Human papillomavirus (HPV) vaccine for girls age 9 to age 22 • Well-child visits for routine examinations, immunizations and care (up to age 22) <ul style="list-style-type: none"> - 6 exams in the first 12 months of life - 2 exams in the 13-24th months of life - 1 exam every 12 months thereafter up to age 18 - 1 exam every 24 months for children age 18 and older • 1 routine eye exam every 12 months • 1 routine hearing exam every 24 months 	<p>In-network: Nothing at a network provider.</p> <p>Out-of-network: Nothing at a non-network provider up to your available Medical Fund balance. Charges above your annual Medical Fund are subject to your member responsibility until satisfied and then subject to Traditional medical coverage (see Section 5).</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> 	<p><i>All charges</i></p>
In-Network Dental Preventive Care	
<p>Preventive care limited to:</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year • Fluoride applications (limited to 1 treatment per calendar year for children under age 16) • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing x-rays (one set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year) <p>Participating network PPO dentists offer members services at a negotiated rate – so, you are generally charged less for your dental care when you visit a participating network PPO dentist. Refer to our DocFind online provider directory at www.aetnafeds.com to find a participating network PPO dentist, or call Member Services at 1-800/537-9384.</p>	<p>In-network: Nothing at a network dentist</p> <p>Out-of-network: Nothing at a non-network dentist up to your available Dental Fund balance. However, you are responsible for non-network dentist fees that exceed our Plan allowance. See Section 5 Dental Fund.</p>

Benefit Description	You pay																																
<p>Medical fund (cont.)</p> <p>To make the most of your Medical Fund, you should:</p> <ul style="list-style-type: none"> • Use the network providers whenever possible; and • Use generic prescriptions whenever possible 	<p>In-network and out-of-network: Nothing up to your annual Medical Fund. Excess Medical Fund dollars from rollovers in previous years will be used to satisfy your member responsibility first, and if excess dollars still remain in the Fund, they can be applied towards your coinsurance and copays under the Traditional Medical Plan coverage. However, you are responsible for non-network medical fees that exceed our Plan allowance.</p>																																
<p><u>Medical Fund Rollover</u></p> <p>Provided you remain enrolled in the CDHP, any unused, remaining balance in your Medical Fund at the end of the calendar year may be rolled over to subsequent years. These rollover dollars will be used to satisfy your member responsibility first, and if any excess remains, these dollars also can be applied towards your coinsurance and copays under the Traditional Medical Plan coverage.</p> <p><u>Example 1: (Claims of \$750)</u></p> <table border="0"> <tr> <td>Annual Medical Fund deposit for Self Only in Year 1</td> <td style="text-align: right;">\$1,250</td> </tr> <tr> <td>Claims paid from the fund</td> <td style="text-align: right;"><u>-750</u></td> </tr> <tr> <td>Balance in Medical Fund rolled over to next year</td> <td style="text-align: right;">\$500</td> </tr> </table> <p><u>Example 2: (Claims of \$1,500)</u></p> <table border="0"> <tr> <td>Annual Medical Fund deposit for Self Only in Year 2</td> <td style="text-align: right;">\$1,250</td> </tr> <tr> <td>Rollover Medical Fund dollars from prior year</td> <td style="text-align: right;"><u>+500</u></td> </tr> <tr> <td>Total Medical Fund available</td> <td style="text-align: right;">\$1,750</td> </tr> <tr> <td>Claims paid from Medical Fund</td> <td style="text-align: right;">\$1,500</td> </tr> <tr> <td>Fund covered \$250 of Member responsibility</td> <td></td> </tr> </table> <p><u>Example 3: (Claims of \$2,500)</u></p> <table border="0"> <tr> <td>Annual Medical Fund deposit for self only in Year 3</td> <td style="text-align: right;">\$1,250</td> </tr> <tr> <td>Rollover Medical Fund from prior year</td> <td style="text-align: right;"><u>\$250</u></td> </tr> <tr> <td>Total Medical Fund available</td> <td style="text-align: right;">\$1,500</td> </tr> <tr> <td>Claims cost of \$2,500</td> <td style="text-align: right;">\$2,500</td> </tr> <tr> <td>Claims paid from Medical Fund (Fund also covers \$250 of your member responsibility)</td> <td style="text-align: right;">\$1,500</td> </tr> <tr> <td>Member responsibility-you pay (\$750-\$250 paid from fund)</td> <td style="text-align: right;"><u>- \$500</u></td> </tr> <tr> <td>Amount paid by Medical Fund and member responsibility</td> <td style="text-align: right;">\$2,000</td> </tr> <tr> <td>Balance of claim (\$2,500-\$2,000)</td> <td style="text-align: right;">\$500</td> </tr> </table>	Annual Medical Fund deposit for Self Only in Year 1	\$1,250	Claims paid from the fund	<u>-750</u>	Balance in Medical Fund rolled over to next year	\$500	Annual Medical Fund deposit for Self Only in Year 2	\$1,250	Rollover Medical Fund dollars from prior year	<u>+500</u>	Total Medical Fund available	\$1,750	Claims paid from Medical Fund	\$1,500	Fund covered \$250 of Member responsibility		Annual Medical Fund deposit for self only in Year 3	\$1,250	Rollover Medical Fund from prior year	<u>\$250</u>	Total Medical Fund available	\$1,500	Claims cost of \$2,500	\$2,500	Claims paid from Medical Fund (Fund also covers \$250 of your member responsibility)	\$1,500	Member responsibility-you pay (\$750-\$250 paid from fund)	<u>- \$500</u>	Amount paid by Medical Fund and member responsibility	\$2,000	Balance of claim (\$2,500-\$2,000)	\$500	<p>In-network and out-of-network: Nothing up to your annual Medical Fund. Excess Medical Fund dollars from rollovers in previous years will be used to satisfy your member responsibility first, and if excess dollars still remain in the Fund, they can be applied towards your coinsurance and copays under the Traditional Medical Plan coverage. However, you are responsible for non-network medical fees that exceed our Plan allowance.</p>
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Benefit Description	You pay
Medical fund (cont.)	
<p>Traditional Plan payment (once your member responsibility has been met - Plan covers 90% of the \$500 balance) - \$450</p> <p>You pay 10% of the \$500 balance under Traditional Plan - <u>\$50</u></p> <p style="text-align: right;">0</p>	<p>In-network and out-of-network: Nothing up to your annual Medical Fund. Excess Medical Fund dollars from rollovers in previous years will be used to satisfy your member responsibility first, and if excess dollars still remain in the Fund, they can be applied towards your coinsurance and copays under the Traditional Medical Plan coverage. However, you are responsible for non-network medical fees that exceed our Plan allowance.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses and contact lenses</i> • <i>Non-network preventive care services not included under Section 5</i> • <i>Services or supplies shown as not covered under Traditional medical coverage (see Section 5)</i> • <i>Charges of non-network providers that exceed our Plan allowance.</i> 	<p><i>All charges</i></p>

Dental fund

Important things you should keep in mind about your Dental Fund 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.
- Note that in-network preventive dental care covered under Section 5 does NOT count against your Dental Fund.
- Provided you remain enrolled in the CDHP, any unused, remaining balance in your Dental Fund at the end of the calendar year, will be rolled over to subsequent years.
- When you join this Plan, you will have access to the entire Dental Fund (\$300 for Self Only or \$600 for Self and Family) to share between you and your enrolled family members.
- Participating network PPO dentists offer members services at a negotiated rate – so, you are generally charged less for your dental care when you visit a participating network PPO dentist. Refer to our DocFind® online provider directory at www.aetnafeds.com to find a participating network PPO dentist, or call Member Services at 1-800/537-9384.
- All eligible dental expenses will be paid from your Dental Fund. You can track your Dental Fund on Aetna’s Navigator Web site or by telephone at 1-800/537-9384. Note: Once your fund is exhausted, you will continue to save on the cost of your dental care with access to the negotiated rates offered by participating network PPO dentists.
- You can visit any licensed dentist for covered services under the Dental Fund. However, you can make your Dental Fund go further by taking advantage of the negotiated rates offered by a participating network PPO dentist. These negotiated rates are generally less than the dentist’s usual fees.
- **REMEMBER:** If you terminate your participation in this Plan, any Dental Fund balance you may have will be lost.

Benefit Description	You pay						
<p>Dental fund</p> <p>Dental Fund expenses include dental services up to a maximum of \$300 for Self Only or \$600 for Self and Family enrollment.</p> <p>The Dental Fund covers eligible expenses at 100%. For example, if you go to a network dentist and incur charges of \$125 for fillings, the dentist will submit your claim and the cost of the visit will be deducted automatically from your Dental Fund; you pay nothing.</p> <table border="0"> <tr> <td>Balance in Dental Fund for Self Only</td> <td>\$300</td> </tr> <tr> <td>Less: Cost of fillings</td> <td>- 125</td> </tr> <tr> <td>Remaining Balance in Dental Fund</td> <td>\$175</td> </tr> </table> <p>Dental Fund Rollover</p> <p>Provided you remain enrolled in the CDHP, any unused remaining balance in your Dental Fund at the end of the calendar year will be rolled over to subsequent years.</p> <p>Eligible dental covered services include:</p> <p>Diagnostic and Preventive Care From Non-Network Dentists:</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year 	Balance in Dental Fund for Self Only	\$300	Less: Cost of fillings	- 125	Remaining Balance in Dental Fund	\$175	<p>Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance.</p> <p>Note: Once your Dental Fund is exhausted, you pay the negotiated rates offered by participating network PPO dentists. You are responsible for the full charges for services accessed from a non-network dentist.</p>
Balance in Dental Fund for Self Only	\$300						
Less: Cost of fillings	- 125						
Remaining Balance in Dental Fund	\$175						

Dental fund - continued on next page

Benefit Description	You pay
<p>Dental fund (cont.)</p> <ul style="list-style-type: none"> • Fluoride applications (limited to 1 treatment per calendar year for children under age 16) • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing x-rays (one set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year) 	<p>Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance.</p> <p>Note: Once your Dental Fund is exhausted, you pay the negotiated rates offered by participating network PPO dentists. You are responsible for the full charges for services accessed from a non-network dentist.</p>
<p>Restorative Care (Basic and Major) from Network or Non-Network Dentists:</p> <ul style="list-style-type: none"> • Amalgam and resin-based composite restorations (“fillings”) • Inlays and onlays • Crowns • Fixed partial dentures (“bridgework”) • Root canal (“endodontics”) therapy, including necessary x-rays • Extractions (oral surgery) such as simple, surgical, soft tissue and bony impacted teeth • Osseous surgery (“periodontics”) - one per quadrant every 3 years, from the last date of service • General anesthesia and intravenous sedation • Repairs to removable partial dentures and complete dentures, within 6 months of installation • Occlusal guards (for bruxism only) – limited to one every 3 years, from the last date of service 	<p>Nothing for eligible expenses until you exhaust your Dental Fund. However, you are responsible for non-network dentist fees that exceed our Plan allowance.</p> <p>Note: Once your Dental Fund is exhausted, you pay the negotiated rates offered by participating network PPO dentists. You are responsible for the full charges for services accessed from a non-network dentist.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthodontia</i> • <i>Dental treatment for cosmetic purposes</i> • <i>Dental care involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> • <i>Dental implants</i> • <i>Replacement of crowns, fixed partial dentures (bridges), removable partial dentures or complete dentures, if the existing crown, fixed partial denture (bridge), removable partial denture or complete denture was originally placed less than 8 years prior to the replacement.</i> • <i>Charges of non-network providers that exceed our Plan allowance</i> 	<p><i>All charges</i></p>

Section 5. Traditional medical coverage subject to the member responsibility

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.
- Your member responsibility is \$750 for Self Only enrollment and \$1,500 for Self and Family enrollment. The Self and Family member responsibility can be satisfied by one or more family members. The member responsibility can be reduced by excess dollars in your Medical Fund as a result of prior year rollovers. The member responsibility applies to all benefits in this Section.
- Your annual Medical Fund of \$1,250 for Self Only enrollment and \$2,500 for Self and Family enrollment must be used first for eligible health care expenses.
- Traditional medical coverage does not begin until you have used your annual Medical Fund and satisfied your member responsibility.
- Prescription drug benefits change to a copayment level once you satisfy your member responsibility. – See section 5 (f)
- In-network medical preventive care is covered at 100% under Section 5 and does not count against your Medical Fund.
- The Medical Fund provides coverage for both network and non-network providers. Under the Traditional medical coverage, in-network benefits apply only when you use a network provider. Out-of-network benefits apply when you do not use a network provider.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY FOR NON-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

Benefit Description	You pay After the calendar year member responsibility ...
Your member responsibility before Traditional medical coverage begins	
<p>Once your annual Medical Fund has been exhausted, you must satisfy your member responsibility before your Traditional medical coverage begins. The Self and Family member responsibility can be satisfied by one or more family members.</p> <p>Once your member responsibility is satisfied, you will be responsible for your coinsurance amounts for eligible medical expenses until you meet the annual catastrophic out-of-pocket maximum. You also are responsible for copayments for eligible prescriptions. However, excess dollars in your Medical Fund from prior year rollovers, if available, will be used to cover coinsurance and copayment amounts under the Traditional Medical Plan.</p>	<p>100% of allowable charges until you meet the member responsibility of \$750 per Self Only enrollment or \$1,500 per Self and Family enrollment. Any unused Medical Fund dollars from prior year rollovers will reduce your member responsibility.</p>

**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.
- Your member responsibility is \$750 for Self Only and \$1,500 for Self and Family enrollment. The Self and Family member responsibility can be satisfied by one or more family members. The member responsibility can be reduced by excess dollars in your Medical Fund as a result of prior year rollovers. The member responsibility applies to all benefits in this Section.
- After you have exhausted your annual Medical Fund and satisfied your member responsibility, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions. If you still have rollover Medical Fund dollars available, once Traditional medical coverage begins, your Medical Fund will cover your coinsurance or copayments until exhausted.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year member responsibility...
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office <ul style="list-style-type: none"> - Office medical consultations - Second surgical or medical opinion - Initial examination of a newborn child covered under a family enrollment • In an urgent care center for a routine service • During a hospital stay • In a skilled nursing facility • At home 	In-network: 10% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	In-network: 10% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year member responsibility...
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits and Surgery benefits. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives and Depo-Provera under the prescription drug benefit.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Reversal of voluntary surgical sterilization, genetic counseling</i>	<i>All charges</i>
Infertility services	
<p>Infertility is defined as the inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination) for women under age 35, and 6 months of unprotected intravaginal sexual relations (or 6 cycles of artificial insemination) for women age 35 and over.</p> <ul style="list-style-type: none"> • Artificial insemination <ul style="list-style-type: none"> - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Infertility services - continued on next page

Benefit Description	You pay After the calendar year member responsibility...
Infertility services (cont.)	
<p>Note: Coverage is only for 3 cycles (per lifetime).</p> <ul style="list-style-type: none"> • Testing for diagnosis and surgical treatment of the underlying cause of infertility. • Fertility drugs except injectables <p>Note: We cover oral fertility drugs under the prescription drug benefit.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>In vitro fertilization</i> - <i>Embryo transfer including, but not limited to, gamete GIFT and zygote ZIFT</i> - <i>Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physicianservices.</i> - <i>Services and supplies related to the above mentioned services, including sperm processing</i> • <i>Reversal of voluntary, surgically-induced sterility.</i> • <i>Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal</i> • <i>Injectable fertility drugs</i> • <i>Infertilitytreatment when the FSH level is 19 mIU/ml or greater on day 3 of menstrual cycle.</i> • <i>The purchase, freezing and storage of donor sperm and donor embryos.</i> 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injection • Allergy serum 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<p><i>All charges.</i></p>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/ Tissue Transplants on page 48.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy — Home IV and antibiotic therapy must be precertified by your attending physician. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year member responsibility...
Treatment therapies (cont.)	
<ul style="list-style-type: none"> Growth hormone therapy (GHT) <p>Note: We cover growth hormone injectables under the prescription drug benefit.</p> <p>Note: We will only cover GHT when we preauthorize the treatment. Call 1-800/245-1206 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and it is authorized by Aetna. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
Physical and occupational therapies	
<ul style="list-style-type: none"> 20 visits per condition per member per calendar year, beginning with the first day of treatment for the services of each of the following: <ul style="list-style-type: none"> Qualified physical therapists Occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Note: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient rehabilitation is covered under Hospital/Extended Care Benefits.</p> <ul style="list-style-type: none"> Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Long-term rehabilitative therapy 	<p><i>All charges</i></p>
Pulmonary and cardiac rehabilitation	
<ul style="list-style-type: none"> 20 visits per condition per member per calendar year for pulmonary rehabilitation to treat functional pulmonary disability. Cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or a myocardial infarction is provided for up to 3 visits a week for a total of 18 visits. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Long-term rehabilitative therapy</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year member responsibility...
Speech therapy	
<ul style="list-style-type: none"> • 20 visits per condition per member per calendar year, beginning with the first day of treatment 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • One hearing exam every 24 months 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Treatment of eye diseases and injury • One routine eye refraction every 12-month period 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> • <i>Corrective eyeglasses and frames or contact lenses</i> • <i>Fitting of contact lenses</i> • <i>Vision therapy, including eye patches and eye exercises, e.g., orthoptics, pleoptics, for the treatment of conditions related to learning disabilities or developmental delays</i> • <i>Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors</i> 	<p><i>All charges</i></p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open manipulation or fixation)</i> • <i>Foot orthotics</i> • <i>Podiatric shoe inserts</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year member responsibility...
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Orthopedic devices such as braces and corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and prosthetic devices such as artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, surgically implanted breast implant following mastectomy, and lenses following cataract removal. See Surgical section for coverage of the surgery to insert the device. • Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.) 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes not attached to a covered brace</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Penile implants</i> 	<p><i>All charges</i></p>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • 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. <p>Note: You must get your DME from a participating DME provider. Some DME may require precertification by you or your physician.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elastic stockings and support hose</i> • <i>Bathroom equipment such as bathtub seats, benches, rails and lifts</i> • <i>Home modifications such as stairglides, elevators and wheelchair ramps</i> • <i>Wheelchair lifts and accessories needed to adapt to the outside environment or convenience for work or to perform leisure or recreational activities</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year member responsibility...
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by your attending Physician and provided by nurses and home health aides. Your attending physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications. <p>Note: Home health services must be precertified by your attending Physician.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family.</i> • <i>Transportation</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Services of a social worker</i> • <i>Services provided by a family member or resident in the member's home.</i> • <i>Services rendered at any site other than the member's home.</i> 	<p><i>All charges</i></p>
Chiropractic	
<p><i>No benefits</i></p>	<p><i>All charges</i></p>
Alternative treatments	
<p><i>No benefits</i></p>	<p><i>All charges</i></p>
Educational classes and programs	
<p>We offer the following Aetna disease management programs at no cost to you:</p> <ul style="list-style-type: none"> • Congestive heart failure • Coronary artery disease • Diabetes • Asthma <p>To request more information on our disease management programs, call 1-800/537-9384.</p>	<p>Nothing</p>

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.
- Your member responsibility is \$750 for Self Only and \$1,500 for Self and Family enrollment. The Self and Family member responsibility can be satisfied by one or more family members. The member responsibility can be reduced by excess dollars in your Medical Fund as a result of prior year rollovers. The member responsibility applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have exhausted your annual Medical Fund and satisfied your member responsibility, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions. If you still have rollover Medical Fund dollars available, once Traditional medical coverage begins, your Medical Fund will cover your coinsurance or copayments until exhausted.
- 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.).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year member responsibility...
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year member responsibility...
Surgical procedures (cont.)	
<ul style="list-style-type: none"> • Surgical treatment of morbid obesity (bariatric surgery) – a condition that has persisted for at least 5 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) – <i>Orthopedic and prosthetic devices</i> for device coverage information <p>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.</p> <ul style="list-style-type: none"> • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns • Skin grafting and tissue implants 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgically-induced sterilization</i> • <i>Surgery primarily for cosmetic purposes</i> • <i>Radial keratotomy and laser surgery, including related procedures designed to surgically correct refractive errors</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year member responsibility...
Reconstructive surgery (cont.)	
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (<i>see Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, that are medical in nature, such as:</p> <ul style="list-style-type: none"> • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ (must be preauthorized); and • Excision of tumors and cysts. <p>Note: When requesting oral and maxillofacial services, please check DocFind or call Member Services at 1-800/537-9384 for a participating oral and maxillofacial surgeon.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Dental implants</i> • <i>Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year member responsibility...
Organ/tissue transplants	
<p>Solid organ transplants are subject to medical necessity and experimental / investigational review. Refer to <i>National Transplant Program (NTP)</i> on page 50 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for 	<p>In-network: 10% of our Plan allowance</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year member responsibility...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolipidosis (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 - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer* - Epithelial ovarian cancer* - Amyloidosis - Ependyoblastoma* - Ewing’s sarcoma - Medulloblastoma - Pineoblastoma* <p>* Approved clinical trial necessary for coverage</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>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:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Benefit Description	You pay After the calendar year member responsibility...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Advanced forms of 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 - Multiple myeloma - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma* - Sarcomas* <p>* Approved clinical trial necessary for coverage</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia* - Chronic myelogenous leukemia* - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma* - Multiple sclerosis* - Systemic lupus erythematosus* - Systemic sclerosis* <p>* Approved clinical trial necessary for coverage</p> <ul style="list-style-type: none"> • National Transplant Program (NTP) - Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your attending doctor and plan specialist and approved by our medical director in advance of the surgery. To receive in-network benefits, the transplant must be performed at hospitals (Institutes of Excellence) specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor until discharge from the hospitalization where the donation occurred, to the extent these services are not covered by another plan or program. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Benefit Description	You pay After the calendar year member responsibility...
Organ/tissue transplants (cont.)	
<p>Note: An accepted donor is covered for evaluations and for medical expenses incurred only during the donation hospitalization.</p> <p>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</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Clinical trials must meet the following criteria:</p> <p>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</p> <p>B. <i>All</i> of the following criteria must be met:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> a. The experimental or investigational drug, device, procedure, or treatment is under current review by the FDA and has an Investigational New Drug (IND) number; and b. The clinical trial has passed review by a panel of independent medical professionals (evidenced by Aetna’s review of the written clinical trial protocols from the requesting institution) approved by Aetna who treat the type of disease involved and has also been approved by an Institutional Review Board (IRB) that will oversee the investigation; and c. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national cooperative body (e.g., Department of Defense, VA Affairs) and conforms to the rigorous independent oversight criteria as defined by the NCI for the performance of clinical trials; and d. The clinical trial is not a single institution or investigator study (NCI designated Cancer Centers are exempt from this requirement); and 4. The member must: <ol style="list-style-type: none"> a. Not be treated “off protocol;” and b. Must actually be enrolled in the trial. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year member responsibility...
Organ/tissue transplants (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>In-network: Nothing</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

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

	<p>Important things you should keep in mind about these benefits:</p> <ul style="list-style-type: none"> • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. • Your member responsibility is \$750 for Self Only and \$1,500 for Self and Family enrollment. The Self and Family member responsibility can be satisfied by one or more family members. The member responsibility can be reduced by excess dollars in your Medical Fund as a result of prior year rollovers. The member responsibility applies to all benefits in this Section. • Be sure to read Section 4, <i>Your costs for covered services</i>, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • After you have exhausted your annual Medical Fund and satisfied your member responsibility, your Traditional Medical Plan begins. • Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions. If you still have rollover Medical Fund dollars available, once Traditional medical coverage begins, your Medical Fund will cover your coinsurance or copayments until exhausted. • Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions. • The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b). • YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY FOR NON-NETWORK FACILITY CARE. Please refer to the precertification information shown in Section 3 to confirm which services require precertification. 	
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Benefit Description	You pay After the calendar year member responsibility
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year member responsibility
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • Blood products, derivatives and components, artificial blood products and biological serum. Blood products include any product created from a component of blood such as, but not limited to, plasma, packed red blood cells, platelets, albumin, Factor VIII, Immunoglobulin, and prolactin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Whole blood and concentrated red blood cells not replaced by the member</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Custodial care, rest cures, domiciliary or convalescent cares</i> • <i>Personal comfort items, such as telephone and television</i> • <i>Private nursing care</i> 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Radiologic procedures, diagnostic laboratory tests, and X-rays when associated with a medical procedure being done the same day • Pathology Services • Administration of blood, blood plasma, and other biologicals • Blood products, derivatives and components, artificial blood products and biological serum • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Whole blood and concentrated red blood cells not replaced by the member.</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year member responsibility
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 60-day limit per calendar year when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All charges</i></p>
Hospice care	
<p>Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of your attending Physician, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less. We allow up to a maximum of \$5,000 for outpatient hospice services and a period not to exceed 30 days for inpatient hospice services.</p> <p>Note: Inpatient hospice services require prior approval.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
Ambulance	
<p>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:</p> <ol style="list-style-type: none"> 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. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency.</i> • <i>Ambulette service.</i> 	<p><i>All charges</i></p>

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.
- Your member responsibility is \$750 for Self Only and \$1,500 for Self and Family enrollment. The Self and Family member responsibility can be satisfied by one or more family members. The member responsibility can be reduced by excess dollars in your Medical Fund as a result of prior year rollovers. The member responsibility applies to all benefits in this Section.
- After you have exhausted your annual Medical Fund and satisfied your member responsibility, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions. If you still have rollover Medical Fund dollars available, once Traditional medical coverage begins, your Medical Fund will cover your coinsurance or copayments until exhausted.
- 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: If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world. An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person’s health, or with respect to a pregnant woman, the health of the woman and her unborn child. If you are admitted to an inpatient facility, you or a family member or friend on your behalf should notify Aetna as soon as possible.

Benefit Description	You pay After the calendar year member responsibility...
Emergency	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient in a hospital, including doctors' services 	In-network or out-of-network: 10% of our Plan allowance
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>

Benefit Description	You pay After the calendar year member responsibility...
Ambulance	
<p>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:</p> <ol style="list-style-type: none"> 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. <p>Note: Air ambulance may be covered. Prior approval is required.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency.</i> • <i>Ambulette service.</i> • <i>Air ambulance without prior approval.</i> 	<p><i>All charges</i></p>

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.
- Your member responsibility is \$750 for Self Only and \$1,500 for Self and Family enrollment. The Self and Family member responsibility can be satisfied by one or more family members. The member responsibility can be reduced by excess dollars in your Medical Fund as a result of prior year rollovers. The member responsibility applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have exhausted your annual Medical Fund and satisfied your member responsibility, your Traditional Medical Plan begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions. If you still have rollover Medical Fund dollars available, once Traditional medical coverage begins, your Medical Fund will cover your coinsurance or copayments until exhausted.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- **Some services must be preauthorized.** We may limit your benefits if you do not obtain a treatment plan for inpatient care.

Benefit Description	You pay After the calendar year member responsibility...
Mental health and substance abuse benefits	
<p>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.</p> <p>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.</p> <p>Outpatient services include:</p> <ul style="list-style-type: none"> • Individual and group therapy performed by licensed providers such as psychiatrists, psychologists, or clinical social workers • Facility based intensive outpatient or partial hospital treatment programs • Outpatient services provided by a hospital or other facility • Diagnostic tests • Medication management 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Benefit Description	You pay After the calendar year member responsibility...
Mental health and substance abuse benefits (cont.)	
<p>Inpatient care includes:</p> <ul style="list-style-type: none"> Both mental health and chemical dependency services provided by an appropriately licensed inpatient facility including licensed residential treatment facilities <p>Note: All inpatient services are subject to precertification. Please call Member Services at 1-800/537-9384 for more information.</p> <p>Note: OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Services we have not approved.</i>	<i>All charges</i>

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. Precertification is 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.

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.
- For prescribed drugs and medications, you must satisfy your annual member responsibility. Your member responsibility is \$750 for Self Only and \$1,500 for Self and Family enrollment. The Self and Family member responsibility can be satisfied by one or more family members. The member responsibility applies to all benefits in this Section and can be reduced by your Medical Fund, if funds are available. While you are meeting this member responsibility, the cost of your prescriptions will be deducted from your Medical Fund, if available, at the time of the purchase. The cost of your prescription is based on the Aetna contracted rate with network pharmacies. The Aetna contracted rate with the network pharmacy does not reflect or include any rebates Aetna receives from drug manufacturers.
- Once you satisfy the member responsibility, you will then pay a copayment at in-network retail pharmacies or the mail-order pharmacy for prescriptions under your Traditional medical coverage. You will pay 40% coinsurance plus the difference between our Plan allowance and the billed amount at out-of-network retail pharmacies. There is no out-of-network mail order pharmacy program. If you have excess rollover Medical Fund dollars, your copayment will be paid from your Medical Fund.
- 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.
- 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.

There are important features you should be aware of which include:

- **Who can write your prescription.** A licensed physician, dentist or licensed practitioner (as allowed by law) must write the prescription.
- **Where you can obtain them.** Any retail pharmacy can be used for up to a 30-day supply. Our mail order program can be utilized for a 31-day up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay (retail pharmacy), and for a 31-day up to a 90-day supply of medication for two copays (mail order). For retail pharmacy transactions, you must present your Aetna Member ID card at the point of sale for coverage. Please call Member Services at 1-800/537-9384 for more details on how to use the mail order program. If accessing a nonparticipating pharmacy, the member must pay the full cost of the medication at the point of service, then submit a complete paper claim and a receipt for the cost of the prescription to our Direct Member Reimbursement (DMR) unit. Reimbursements are subject to review to determine if the claim meets applicable requirements, and are subject to the terms and conditions of the benefit plan and applicable law.
- **We use a formulary.** Drugs are prescribed by licensed attending doctors and covered in accordance with the Plan's drug formulary; however, coverage is not limited to medications included on the formulary. Many non-formulary drugs are also covered but a higher copayment will apply. Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Visit our Web site at www.aetnafeds.com to review our Formulary Guide or call 1-800/537-9384.

Prescription drug benefits continued on next page

- **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.
- **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.
- **When to use a participating retail or mail order pharmacy.** Covered prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy may be dispensed for up to a 30-day supply. Members must obtain a 31-day up to a 90-day supply of covered prescription medication through mail order (applies to in-network pharmacies only). In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available, unless your physician specifically requires a brand name. Drug costs are calculated based on Aetna’s contracted rate with the network pharmacy excluding any drug rebates.
- In the event that a member is called to active military duty and requires coverage under their prescription plan benefits of an additional filling of their medication(s) prior to departure, their pharmacist will need to contact Aetna. Coverage of additional prescriptions will only be allowed if there are refills remaining on the member’s current prescription or a new prescription has been issued by their physician. The member is responsible for the applicable copayment for the additional prescription.
- Aetna allows coverage of a medication filling when at least 75% of the previous prescription according to the physician’s prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a new prescription to be covered on the 23rd day, thereby allowing a member to have an additional supply of their medication, in case of emergency.
- **Why use generic drugs?** Generics contain the same active ingredients in the same amounts as their brand name counterparts and have been approved by the FDA. By using generic drugs, when available, most members see cost savings, without jeopardizing clinical outcome or compromising quality.
- **When you do have to file a claim.** Send your itemized bill(s) to: Aetna, Pharmacy Management, Claim Processing, P.O. Box 14024, Lexington, KY 40512-4024.

Benefit Description	You pay After the calendar year member responsibility...
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by your licensed attending physician or dentist and obtained from a Plan pharmacy or through our mail order program or an out-of-network retail pharmacy:</p>	<p>In-network:</p> <p>The full cost of the prescription is applied to the member responsibility before any benefits are considered for payment under the pharmacy plan. Once the member responsibility is satisfied, the following will apply:</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year member responsibility...
Covered medications and supplies (cont.)	
<ul style="list-style-type: none"> • Drugs and medicines approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as <i>Not Covered</i> • Self-injectable drugs • Contraceptive drugs and devices • Oral fertility drugs • Diabetic supplies limited to lancets, alcohol swabs, urine test strips/ tablets, and blood glucose test strips • Insulin • Disposable needles and syringes for the administration of covered medications 	<p>Retail Pharmacy, for up to a 30-day supply per prescription or refill:</p> <p>\$10 per covered generic formulary drug;</p> <p>\$25 per covered brand name formulary drug; and</p> <p>\$40 per covered non-formulary (generic or brand name) drug.</p> <p>Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill:</p> <p>\$20 per covered generic formulary drug</p> <p>\$50 per covered brand name formulary drug; and</p> <p>\$80 per covered non-formulary (generic or brand name) drug.</p> <p>Out-of-network (retail pharmacies only):</p> <p>40% plus the difference between our Plan allowance and the billed amount.</p>
<p>Limited benefits:</p> <ul style="list-style-type: none"> • Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits 	<p>In-network:</p> <p>50%</p>
<ul style="list-style-type: none"> • Imitrex (limited to 48 kits per calendar year) 	<p>\$25/kit</p>
<ul style="list-style-type: none"> • Depo-Provera is limited to 5 vials per calendar year 	<p>\$25 copay per vial</p>
<ul style="list-style-type: none"> • One diaphragm per calendar year 	<p>\$25 per diaphragm</p>
	<p>Out-of-network (retail pharmacies only):</p> <p>40% plus the difference between our Plan allowance and the billed amount, except for drugs to treat sexual dysfunction which are 50% plus the difference between our Plan allowance and the billed amount.</p>

Covered medications and supplies continued on next page

Benefit Description	You pay After the calendar year member responsibility...
Covered medications and supplies (cont.)	

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 members’ medical benefits, now are covered under their Aetna 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-Monoclonal 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 2008 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 at www.aetnafeds.com for current Medication Formulary Guide information.

Benefit Description	You pay... After the calendar year member responsibility...
Covered medications and supplies (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs used for the purpose of weight reduction, such as appetite suppressants</i> • <i>Drugs for cosmetic purposes, such as Rogaine</i> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug)</i> • <i>Lost, stolen or damaged drugs</i> • <i>Vitamins, nutritional and dietary substances/supplements that can be purchased without prescription</i> • <i>Smoking cessation drugs and medication including, but not limited to, nicotine patches and sprays</i> • <i>Prophylactic drugs including, but not limited to, anti-malarials for travel</i> 	<p><i>All charges</i></p>

Section 5(g). Special features

Feature	Description
Aetna IntelliHealth	<p>Aetna IntelliHealth.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 Aetna IntelliHealth to provide trusted and credible health information to its users. Aetna IntelliHealth features include: a Drug Resource Center, Disease and Condition Management tools, the Harvard Symptom Scout (an interactive symptom checker that provides guidance about a variety of symptoms), Daily Health News and much more. Visit Aetna IntelliHealth at www.aetnafeds.com.</p>
Aetna Navigator	<p>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.</p> <p>With Aetna Navigator, you can:</p> <ul style="list-style-type: none"> • 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 Intellihealth and Healthwise® Knowledgebase • Check fund balances <p>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.</p>
Informed Health Line	<p>Provides eligible members with telephone access to registered nurses experienced in providing information on a variety of health topics. Informed Health Line is available 24 hours a day, 7 days a week. You may call Informed Health Line at 1-800/556-1555. Through Informed Health Line, members also have 24-hour access to an audio health library – equipped with information on more than 2,000 health topics, and accessible on demand through any touch tone telephone. Topics are available in both English and Spanish. We provide TDD service for the hearing and speech-impaired. We also offer foreign language translation for non-English speaking members. Informed Health Line nurses cannot diagnose, prescribe medication or give medical advice.</p>
Services for the deaf and hearing-impaired	1-800/628-3323

High Deductible Health Plan Benefits

See pages 15-16 for how our benefits changed this year and pages 140-141 for a benefits summary.

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Summary of benefits for the HDHP of the Aetna HealthFund Plan - 2008140

Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this Section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read the important things you should keep in mind about these benefits. Also read the General Exclusions in Section 6 they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 1-800/537-9384 or at our Web site at www.aetnafeds.com.

Our HDHP option provides traditional health care coverage and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this Plan, in-network preventive care is covered in full. As you receive other non-preventive medical care, you must meet the Plan’s deductible before we pay benefits according to the benefits described on page 84. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: in-network medical and dental preventive care; traditional medical coverage that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools, such as online, interactive health and benefits information tools to help you make more informed health decisions.

- In-Network Medical, and Dental Preventive Care**

The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., routine mammograms), well-child care, routine child and adult immunizations, and routine oral evaluations and cleaning of your teeth. These services are covered at 100% if you use a network provider. The services are described in Section 5, In-Network Medical, and Dental Preventive Care.

You do not have to meet the deductible before using these services. This does not reduce your HSA or HRA.

- Traditional medical coverage subject to the deductible**

After you have paid the Plan’s deductible (In-network: \$1,500 for Self Only enrollment and \$3,000 for Self and Family enrollment or Out-of-network: \$2,500 for Self Only enrollment and \$5,000 for Self and Family enrollment), we pay benefits under Traditional medical coverage described in Section 5. The Plan typically pays 90% for in-network care and 70% for out-of-network care.

Covered services include:

- Medical services and supplies provided by physicians and other health care professionals
- Surgical and anesthesia services provided by physicians and other health care professionals
- Hospital services; other facility or ambulance services
- Emergency services/accidents
- Mental health and substance abuse benefits
- Prescription drug benefits
- Special features

Savings

Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see Sections 3, 4, and 5 for more details).

Health Savings Accounts (HSA)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else’s tax return, have not received VA benefits within the last three months, or do not have other health insurance coverage other than another high deductible health plan. In 2008, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$62.50 per month for a Self Only enrollment or \$125 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is \$2,900 for Self Only enrollment and \$5,800 for Self and Family enrollment for 2008. The IRS allows you to contribute up to \$900 in catch-up contributions for 2008, if you are age 55 or older. See maximum contribution information on page 72. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

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

HSA features include:

- JP Morgan Chase Bank, N.A. has been selected by Aetna to provide debit card, checkbook and record-keeping services. Aetna remains custodian for the HSA accounts.
- Your contributions to the HSA are tax deductible.
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest or any investment gains through a choice of investment options.
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents. (See IRS publication 502 for a complete list of eligible expenses.) A link to this publication can also be found at www.aetnafeds.com.
- Your unused HSA funds and interest accumulate from year to year.
- It’s portable – the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire.
- When you need it, funds up to the actual HSA balance are available.

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a (HCFSA) (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

If you aren’t eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2008, we will give you an HRA credit of \$750 per year for a Self Only enrollment and \$1,500 per year for a Self and Family enrollment. Your HRA will be used to help pay for covered services that apply towards your health plan deductible and/or for certain qualified medical expenses that don’t count toward the deductible. (See IRS publication 502 for a list of qualified medical expenses).

HRA features include:

- For our HDHP option, the HRA is administered by Aetna Life Insurance Company.
- Entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment.
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP.
- Unused credits carryover from year to year.
- HRA credit does not earn interest.
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans.
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements. See *Who Is Eligible to Enroll?* in Section 12 under The Federal Flexible Spending Account Program – *FSAFEDS*.

• **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to \$4,000 for Self Only or \$8,000 for Self and Family enrollment. If you use non-network providers, your out-of-pocket maximum is \$5,000 for Self Only or \$10,000 for Self and Family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s allowable amount or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 *Traditional medical coverage subject to the deductible* for more details.

• **Health education resources and account management tools**

HDHP Section 5(h) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

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

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

Aetna Navigator gives you direct access to:

- Personal Health Record that provides you with online access to your personal health information including health care providers, drug prescriptions, medical tests, individual personalized messages, alerts and a detailed health history that can be shared with your physicians.
- The Price-A-Medical ProcedureSM tool to compare network physician fees for select services to typical fees outside the network.
- Estimate the Cost of CareSM that allows you to compare the estimated average costs for 200 different health care services in your area.
- Price-A-Dental ProcedureSM tool to compare network dental fees for select services with typical fees outside the network.
- Price-A-DrugSM tool to estimate the cost of your prescription if obtained at a participating retail or mail order pharmacy.
- A hospital comparison tool that allows you to see how hospitals in your area rank on measures important to your care.
- Our DocFind® online provider directory.

- Online customer service that allows you to request member ID cards, send secure messages to Member Services, and more.
- Healthwise[®] Knowledgebase where you get information on thousands of health-related topics to help you make better decisions about your health care and treatment options.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	<p>The Plan will establish an HSA for you with Aetna Life Insurance Company, this HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS).</p> <p>HSA will be administered by JPMorganChase Bank, N.A. Aetna remains custodian of the HSA accounts.</p> <p>Aetna Life Insurance Company Federal Plans PO Box 550 Blue Bell, PA 19422-0550 1-800/537-9384 www.aetnafeds.com</p>	<p>Aetna Life Insurance Company is the HRA fiduciary for this Plan.</p> <p>Aetna Life Insurance Company Federal Plans PO Box 550 Blue Bell, PA 19422-0550 1-800/537-9384 www.aetnafeds.com</p>
Fees	<p>There is no HSA set-up fee.</p> <p>The administrative fee is covered in the premium while the member is covered under the HDHP.</p> <p>When using a Chase or Bank One ATM, there are no ATM fees. However, certain banking fees may apply. You can find the fee schedule at the end of this section on page 76.</p> <p>If you are no longer covered under the HDHP, there is a \$3 administrative fee that will be deducted from your HSA account every month.</p>	None
Eligibility	<p>You must:</p> <ul style="list-style-type: none"> • Enroll in the Aetna HealthFund High Deductible Health Plan (HDHP). • Have no other health insurance coverage (does not apply to another HDHP plan, specific injury, accident, disability, dental, vision, or long term care coverage). • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's tax return. • Not have received VA benefits in the last three months. • Complete and return all banking paperwork. 	<p>You must enroll in the Aetna HealthFund High Deductible Health Plan (HDHP).</p> <p>Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.</p>

<p>Funding</p>	<p>If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP.</p> <p>In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).</p> <p>You may contribute to your HSA by submitting an Aetna HSA deposit slip with your contribution up to the maximum allowed. The deadline for HSA contributions is April 15 following the year for which contributions are made. When making contributions for a previous tax year, use the Tax Year Designation Change for Contributions to HSA form. You can obtain additional HSA forms by logging into the Aetna Navigator Web site at www.aetnafeds.com.</p>	<p>Eligibility for the annual credit will be determined on the first day of the month and will be prorated for length of enrollment. The entire amount of your HRA will be available to you upon your enrollment.</p>
<p>• Self Only enrollment</p>	<p>For 2008, a monthly premium pass through of \$62.50 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2008, your HRA annual credit is \$750 (prorated for mid-year enrollment).</p>
<p>• Self and Family enrollment</p>	<p>For 2008, a monthly premium pass through of \$125 will be made by the HDHP directly into your HSA each month.</p>	<p>For 2008, your HRA annual credit is \$1,500 (prorated for mid-year enrollment).</p>
<p>Contributions/credits</p>	<p>The maximum that can be contributed to your HSA is an annual combination of the HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the annual statutory dollar maximum, which is \$2,900 for Self Only coverage and \$5,800 for Self and Family coverage for 2008.</p> <p>If you are age 55 or older, the IRS allows you to contribute up to \$900 in catch-up contributions.</p> <p>If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution.</p>	<p>The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest. You cannot contribute to the HRA.</p>

<p>Contributions/credits (cont.)</p>	<p>You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year.</p> <p>If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.</p> <ul style="list-style-type: none"> • You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). • You are able to make a one-time, tax-free, irrevocable, trustee-to-trustee rollover from your IRA to your HSA. The amount that may be rolled over from an IRA to an HSA is limited to the amount of your maximum annual HSA contribution limit for the year in which the rollover is made. Any amount you rollover from an IRA will count towards your annual HSA contribution limit so you will need to make sure that the amount you transfer from your IRA combined with your other HSA contributions for the year do not exceed the annual HSA contribution limit. • HSAs earn tax-free interest (does not affect your annual maximum contribution). • Catch-up contribution discussed on page 77. 	
<ul style="list-style-type: none"> • Self Only enrollment 	<p>You may make a voluntary annual maximum contribution of \$2,150.</p>	<p>You cannot contribute to the HRA.</p>
<ul style="list-style-type: none"> • Self and Family enrollment 	<p>You may make a voluntary annual maximum contribution of \$4,300.</p>	<p>You cannot contribute to the HRA.</p>
<p>Access funds</p>	<p>You can access your HSA by the following methods:</p> <ul style="list-style-type: none"> • Debit Card – The Debit Card must be activated in order to have access to HSA Funds, customer service and online information. • By check (if purchased). 	<p>For covered medical expenses under your HDHP, claims will be paid automatically by your HRA when claims are submitted to Aetna, if there is money available in your HRA.</p>

<p>Access funds (cont.)</p>	<ul style="list-style-type: none"> • AutoDebit Option - Aetna HSA AutoDebit is a fast, easy and automatic way to pay out-of-pocket health expenses from your HSA. If you are a member of an Aetna High Deductible Health Plan (HDHP) and enrolled in an Aetna Health Savings Account (HSA), you can elect to have money withdrawn directly from your HSA to pay for qualified out-of-pocket expenses, paying the doctor directly, without having to use your Aetna HSA Visa debit card or checks. This feature will be available 1/1/2008. 	
<p>Distributions/withdrawals</p> <ul style="list-style-type: none"> • Medical 	<p>You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA.</p> <p>Medical expenses are not allowable if they occur before the first full month your enrollment is effective, and they are not reimbursable from your HSA, which is established the first of the month following the effective date of your enrollment in this HDHP and the date your HSA account is established.</p> <p>For most Federal enrollees (those not paid on a monthly basis), the earliest date medical expenses will be allowable is February 1, 2008. If you were covered under the HDHP in 2007 and remain enrolled in this HDHP, your medical expenses incurred January 1, 2008 or later, will be allowable.</p> <p>See IRS Publication 502, which you can access at www.aetnafeds.com, for a list of qualified eligible medical expenses, including over-the-counter drugs.</p>	<p>You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP.</p> <p>Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. You must submit these expenses with a claim form (available on our website www.aetnafeds.com) for reimbursement.</p> <p>See <i>Availability of funds</i> below for information on when funds are available in the HRA.</p> <p>See IRS Publication 502 for a list of qualified eligible medical expenses. Over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.</p>
<ul style="list-style-type: none"> • Non-medical 	<p>If you are under age 65, withdrawal of funds for non-medical expenses will create a 10% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.</p> <p>When you turn age 65, distributions can be used for any reason without being subject to the 10% penalty, however they will be subject to ordinary income tax.</p>	<p>Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.</p>

<p>Availability of funds</p>	<p>Funds are not available for withdrawal until all the following steps are completed:</p> <ul style="list-style-type: none"> - Your enrollment in this HDHP is effective (effective date is determined by your agency in accordance with the event permitting the enrollment change). - The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. - The fiduciary sends you HSA paperwork for you to complete and the fiduciary receives the completed paperwork back from you. <p>After the plan administrator receives enrollment and contributions from OPM and your HSA account has been created by JPMorganChase and funded, the enrollee can withdraw funds up to the amount contributed for any expenses incurred on or after the date the HSA was initially established.</p>	<p>Funds are not available until:</p> <ul style="list-style-type: none"> • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The entire amount of your HRA will be available to you upon your enrollment in the HDHP.
<p>Account owner</p>	<p>FEHB enrollee</p>	<p>Aetna Life Insurance Company</p>
<p>Portable</p>	<p>You can take this account with you when you change plans, separate or retire.</p> <p>If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 68 for HSA eligibility</p>	<p>If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA.</p> <p>If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.</p>
<p>Annual rollover</p>	<p>Yes, accumulates without a maximum cap.</p>	<p>Yes, accumulates without a maximum cap.</p>

Fees for Federal Employees Health Benefits Program

Fee Description	Fee
Monthly Account Maintenance	No charge
ATM Withdrawal *	No charge
ATM Balance Inquiry	No charge
ATM/Point-of-Service Denial	No charge
Returned Deposit Check	\$15.00 per returned deposit check
Checkbook Checks	\$10.00 per book of 25 checks purchased**
Copies of Processed Checks	\$10.00 per check
Checks Returned for Non-sufficient Funds	\$20.00 per returned check
Stop Payment of Check	\$20.00 per stopped check
Supplemental EFT*** Contribution	\$5.00 per contribution****
Returned EFT Deposit	\$15.00 per EFT deposit return
Foreign Currency Conversion	2.5% of purchase amount
Account Closing by Check	No charge
Cash Advance (over the counter cash withdrawal at a bank branch)	\$5.00 per withdrawal
Replacement of Lost/Stolen HSA Debit Card	\$5.00 (expedited shipping will be an additional charge)

* You may be charged an additional ATM usage fee if you use a non-Chase or Bank One ATM for any HSA transaction. Usage fees will vary by ATM operators.

** Additional sales tax may apply.

*** Electronic Funds Transfer (EFT)

**** Fee only applies to one-time EFT withdrawals from your checking account. There is no fee for monthly EFT withdrawals from your checking account.

If you have an HSA

• **Contributions**

All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or through Electronic Fund Transfer deposits that are withdrawn from your personal bank accounts, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain hour HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

• **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional “catch-up” contributions to your HSA. In 2008, you may contribute up to \$900 in catch-up contributions. The allowable catch-up contribution will be \$1,000 in 2009 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

Spouse catch-up contributions must be established in a separate HSA account from that of the employee. Please contact your plan administrator for details.

• **If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse’s HSA; otherwise, it becomes part of your taxable estate.

• **Investment Options**

Account holders who exceed the minimum required balance of \$2,000 in their HSA cash account, will have a number of different investment options to choose from in 2008 and will be offered by different organizations that have been selected by Aetna. Participation in these options will be entirely optional and neither Aetna nor JPMorganChase Bank, N. A. is or will be acting in the capacity of a registered investment advisor. Balances in these investment options may fluctuate up or down and will not be insured by the FDIC or other government agencies.

Aetna will make available eight (8) HSA investment options, as defined below, to account holders who exceed the minimum required balance of \$2,000 in their HSA cash account. (Additional investments may be made available at a later date.)

These funds are distributed through JPMorgan Distribution Services, Inc., and are not offered or insured by Aetna or JPMorganChase Bank, N.A. (JPMC). Participation in these options will be entirely optional, and neither Aetna nor JPMC is or will be acting in the capacity of a registered investment advisor with respect to these options. Balances in the funds may fluctuate and will not be insured by the FDIC or other government agency.

Three(3) Asset Allocation Funds:

- JPMorgan Investor Conservative Growth Fund A
- JPMorgan Investor Balanced Fund A
- JPMorgan Investor Growth Fund A

Two (2) Fixed Income Funds:

- JPMorgan Prime Money Market Fund
- JPMorgan Core Bond Fund A

Two (2) US Equity Funds:

- JPMorgan Equity Index Fund A
- JPMorgan Small Cap Equity Fund A

One (1) International Equity Fund:

- JPMorgan International Equity A

• **Qualified expenses**

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

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

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800/829-3676, or visit the IRS Web site at www.irs.gov and click on “Forms and Publications”. Note: Although over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

• **Non-qualified expenses**

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

• **Tracking your HSA balance**

You can view account activity such as the “premium pass through,” withdrawals, and interest earned on your account, as well as account balances online on Aetna Navigator. You can also request a paper monthly activity statement at no additional charge.

• **Minimum reimbursements from your HSA**

There no longer is any minimum withdrawal or distribution amount.

If you have an HRA

• **Why an HRA is established**

If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you are or become ineligible to contribute to an HSA.

• **How an HRA differs**

Please review the chart beginning on page 71 which details the differences between an HRA and HSA. The major differences are:

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

Section 5. In-Network Medical and Dental Preventive Care

Important things you should keep in mind about these in-network medical and dental preventive care benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Preventive care is health care services designed for prevention and early detection of illness in average risk, asymptomatic people, generally including routine physical examinations, tests and immunizations.
- The Plan pays 100% for the medical and dental preventive care services listed in this Section as long as you use a network provider.
- If you choose to access preventive care from a non-network provider, you will not qualify for 100% preventive care coverage. Please see Section 5 – Traditional medical coverage subject to the deductible.
- For preventive care not listed in this Section, preventive care from a non-network provider, or any other covered expenses, please see Section 5 – Traditional medical coverage subject to the deductible.
- Note that the in-network preventive care paid under this Section does NOT count against or use up your HSA or HRA.

Benefit Description	You pay	
	HSA	HRA
In-Network Medical Preventive Care, adult		
Routine screenings, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Total Blood Cholesterol • 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 • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test yearly starting at age 50, - Sigmoidoscopy screening — every five years starting at age 50, - Double contrast barium enema — every five years starting at age 50; - Colonoscopy screening — every 10 years starting at age 50 • Abdominal Aortic Aneurysm Screening – Ultrasonography, one screening for men between the age of 65 and 75 with a smoking history • Routine annual digital rectal exam (DRE) for men age 40 and older • Human papilloma virus (HPV) screening covered when done in combination with a Pap test for women ages 30 and older 	In-network: Nothing at a network provider. Out-of-network: All charges until you satisfy your deductible, then 30% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.	In-network: Nothing at a network provider. Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.

In-Network Medical Preventive Care, adult - continued on next page

Benefit Description	You pay	
In-Network Medical Preventive Care, adult (cont.)	HSA	HRA
<ul style="list-style-type: none"> • Routine well-woman exam including Pap test, one visit every 12 months from last date of service • Routine mammogram — covered for women age 35 and older, as follows: <ul style="list-style-type: none"> - From age 35 through 39, one during this five year period - From age 40 to 64, one every calendar year - At age 64 and older, one every 2 consecutive calendar years • Routine physicals: <ul style="list-style-type: none"> - One exam every 24 months up to age 65 - One exam every 12 months age 65 and older • Routine Osteoporosis Screening: <ul style="list-style-type: none"> - For women 65 and older - At age 60 for women at increased risk • Adult routine immunizations, such as: <ul style="list-style-type: none"> - 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 over - Human papillomavirus (HPV) vaccine for women age 18 through age 26 - Herpes Zoster (Shingles) vaccine for all persons age 60 and older • Exams and eyewear limited to: <ul style="list-style-type: none"> - 1 routine eye exam every 12 months - 1 routine OB/GYN exam every 12 months including 1 Pap smear and related services - 1 routine hearing exam every 24 months - Corrective eyeglasses and frames or contact lenses (hard or soft) per 24-month period up to a Plan allowance of \$100. 	<p>In-network: Nothing at a network provider.</p> <p>Out-of-network: All charges until you satisfy your deductible, then 30% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.</p>	<p>In-network: Nothing at a network provider.</p> <p>Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams, immunizations, and boosters required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay	
In-Network Medical Preventive Care, children	HSA	HRA
<p>Childhood immunizations recommended by the American Academy of Pediatrics</p> <ul style="list-style-type: none"> • 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. • 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 <p>Examinations, such as:</p> <ul style="list-style-type: none"> • Well-child visits for routine examinations, immunizations and care (up to age 22) <ul style="list-style-type: none"> - 6 exams in the first 12 months of life - 2 exams in the 13-24th months of life - 1 exam every 12 months thereafter up to age 18 - 1 exam every 24 months for children age 18 and older • 1 routine eye exam every 12 months through age 17 to determine the need for vision correction • 1 routine hearing exam every 24 months through age 17 to determine the need for hearing correction 	<p>In-network: Nothing at a network provider</p> <p>Out-of-network: All charges until you satisfy your deductible, then 30% of our Plan allowance and any difference between our allowance and the billed amount under Traditional medical coverage (Section 5). However, you may elect to use your HSA account to pay the bill, up to your HSA balance.</p>	<p>In-network: Nothing at a network provider</p> <p>Out-of-network: Nothing at a non-network provider up to your available HRA Fund balance. Charges above the available HRA Fund balance, according to the Traditional medical coverage (Section 5), and the deductible.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams, immunizations and boosters required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay	
In-Network Dental Preventive Care	HSA	HRA
<p>Preventive care limited to:</p> <ul style="list-style-type: none"> • Prophylaxis (cleaning of teeth) – limited to 2 treatments per calendar year • Fluoride applications (limited to 1 treatment per calendar year for children under age 16) • Sealants – (once every 3 years, from the last date of service, on permanent molars for children under age 16) • Space maintainer (primary teeth only) • Bitewing x-rays (one set per calendar year) • Complete series x-rays (one complete series every 3 years) • Periapical x-rays • Routine oral evaluations (limited to 2 per calendar year) 	<p>In-network: Nothing at a network dentist</p> <p>Out-of-network: All charges</p>	<p>In-network: Nothing at a network dentist</p> <p>Out-of-network: All charges</p>
<p>Participating network PPO dentists offer members services at a negotiated rate – so, you are generally charged less for your dental care when you visit a participating network PPO dentist. Refer to our DocFind online provider directory at www.aetnafeds.com to find a participating network PPO dentist, or call Member Services at 1-800/537-9384.</p>		
<p><i>Not covered: We offer no other dental benefits other than those shown above.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5. Traditional medical coverage subject to the deductible

Important things you should keep in mind about these benefits:

- Traditional medical coverage does not begin to pay until you have satisfied your deductible.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In-network medical preventive care is covered at 100% (see page 80) and is not subject to your calendar year deductible.
- The deductible is: In-network - \$1,500 for Self Only enrollment and \$3,000 for Self & Family enrollment or Out-of-Network - \$2,500 per Self Only or \$5,000 per Self and Family enrollment. The family deductible can be satisfied by one or more family members. You must satisfy your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, in-network benefits apply only when you use a network provider. Out-of-network benefits apply when you do not use a network provider. Your dollars will generally go further when you use network providers because network providers agree to discount their fees.
- Whether you use network or non-network providers, you are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your coinsurance, copayments and deductibles total \$4,000 in-network and \$5,000 out-of-network per person or \$8,000 in-network and \$10,000 out-of-network per family enrollment in any calendar year, you do not have to pay any more for covered services from network or non-network providers. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan’s benefit maximum, or if you use out-of-network providers, amounts in excess of the Plan allowance).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Deductible before Traditional medical coverage begins	HSA	HRA
<p>You must satisfy your deductible before your Traditional medical coverage begins. The Self and Family deductible can be satisfied by one or more family members.</p> <p>Once your Traditional medical coverage begins, you will be responsible for your coinsurance amounts for eligible medical expenses or copayments for eligible prescriptions, until you reach the annual catastrophic protection out-of-pocket maximum. At that point, we pay eligible medical expenses for the remainder of the calendar year at 100%.</p>	<p>100% of allowable charges until you meet the deductible: In-network: \$1,500 for Self Only enrollment and \$3,000 for Self & Family enrollment or Out-of-Network: \$2,500 per Self Only enrollment or \$5,000 per Self and Family enrollment. You can use your HSA to help satisfy your deductible.</p>	<p>100% of allowable charges until you meet the deductible: In-network: \$1,500 for Self Only enrollment and \$3,000 for Self & Family enrollment or Out-of-Network: \$2,500 per Self Only enrollment or \$5,000 per Self and Family enrollment. Your HRA Fund counts towards your deductible.</p> <p>Your HRA fund (\$750/\$1,500) is used first. Then you must pay the remainder of the deductible (e.g. In-network \$1,500/\$3,000) out-of-pocket i.e., \$750/\$1,500.</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - \$1,500 for Self Only enrollment and \$3,000 for Self & Family enrollment or Out-of-Network - \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After the calendar year deductible...
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office <ul style="list-style-type: none"> - Office medical consultations - Second surgical or medical opinion - Initial examination of a newborn child covered under a family enrollment • In an urgent care center for a routine service • During a hospital stay • In a skilled nursing facility • At home 	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Benefit Description	You pay After the calendar year deductible...
Maternity care	
<ul style="list-style-type: none"> • Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if medically necessary but you, your representatives, your doctor, or your hospital must recertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See <i>Hospital benefits</i> (Section 5c) and <i>Surgery benefits</i> (Section 5b). 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See <i>Surgical procedures</i> (Section 5b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives and Depo-Provera under the prescription drug benefit.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered:</i>	<i>All charges</i>
<ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling.</i> 	
Infertility services	
<p>Infertility is defined as the inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination) for women under age 35, and 6 months of unprotected intravaginal sexual relations (or 6 cycles of artificial insemination) for women age 35 and over.</p> <p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination <ul style="list-style-type: none"> - intravaginal insemination (IVI) 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Infertility services - continued on next page
 HDHP Section 5(a)

Benefit Description	You pay After the calendar year deductible...
Infertility services (cont.)	
<ul style="list-style-type: none"> - intracervical insemination (ICI) - intrauterine insemination (IUI) <p>Note: Coverage is only for 3 cycles (per lifetime).</p> <ul style="list-style-type: none"> • Testing for diagnosis and surgical treatment of the underlying cause of infertility. • Fertility drugs except injectables <p>Note: We cover oral fertility drugs under the prescription drug benefit.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer including, but not limited to, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> - <i>services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services.</i> - <i>services and supplies related to the above mentioned services, including sperm processing</i> • <i>Reversal of voluntary, surgically-induced sterility.</i> • <i>Treatment for infertility when the cause of the infertility was a previous sterilization with or without surgical reversal</i> • <i>Injectable fertility drugs</i> • <i>Infertility treatment when the FSH level is 19 mIU/ml or greater on day 3 of menstrual cycle.</i> • <i>The purchase, freezing and storage of donor sperm and donor embryos.</i> 	<p><i>All charges</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections • Allergy serum 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges</i></p>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 94.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV) Infusion Therapy — Home IV and antibiotic therapy must be precertified by your attending physician. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...
Treatment therapies (cont.)	
<ul style="list-style-type: none"> Growth hormone therapy (GHT) <p>Note: We cover growth hormone injectables under the prescription drug benefit.</p> <p>Note: We will only cover GHT when we preauthorize the treatment. Call 1-800/245-1206 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information and it is authorized by Aetna. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
Physical and occupational therapies	
<ul style="list-style-type: none"> 20 visits per condition per member per calendar year, beginning with the first day of treatment for the services of each of the following: <ul style="list-style-type: none"> Qualified physical therapists Occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <p>Note: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient rehabilitation is covered under Hospital/Extended Care Benefits.</p> <ul style="list-style-type: none"> Physical therapy to treat temporomandibular joint (TMJ) pain dysfunction syndrome 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Long-term rehabilitative therapy 	<p><i>All charges</i></p>
Pulmonary and cardiac rehabilitation	
<ul style="list-style-type: none"> 20 visits per condition per member per calendar year for pulmonary rehabilitation to treat functional pulmonary disability. Cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or a myocardial infarction is provided for up to 3 visits a week for a total of 18 visits. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Long-term rehabilitative therapy</i></p>	<p><i>All charges</i></p>
Speech therapy	
<ul style="list-style-type: none"> 20 visits per condition per member per calendar year, beginning with the first day of treatment 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Benefit Description	You pay After the calendar year deductible...
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • One hearing exam every 24 months for children through age 17 (see <i>In-Network Medical Preventive Care, children</i>) • One hearing exam every 24 months for adults (see <i>In-Network Medical Preventive Care, adult</i>) 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<i>Not covered: Hearing aids, testing and examinations for them</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Treatment of eye diseases and injury • One routine eye refraction every 12-month period 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Fitting of contact lenses</i> • <i>Vision therapy, including eye patches and eye exercises, e.g., orthoptics, pleoptics, for the treatment of conditions related to learning disabilities or developmental delays</i> • <i>Radial keratotomy and laser eye surgery, including related procedures designed to surgically correct refractive errors</i> 	<i>All charges</i>
Foot care	
<ul style="list-style-type: none"> • Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open manipulation or fixation)</i> • <i>Foot orthotics</i> • <i>Podiatric shoe inserts</i> 	<i>All charges</i>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Orthopedic devices such as braces and corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome and prosthetic devices such as artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy, and lenses following cataract removal. Note: See Section 5(b) for coverage of the surgery to insert the device. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...
Orthopedic and prosthetic devices (cont.)	
<ul style="list-style-type: none"> Ostomy supplies specific to ostomy care (quantities and types vary according to ostomy, location, construction, etc.) 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Orthopedic and corrective shoes not attached to a covered brace Arch supports Foot orthotics Heel pads and heel cups Podiatric shoe inserts Lumbosacral supports Penile implants 	<p><i>All charges</i></p>
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> 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. <p>Note: You must get your DME from a participating DME provider. Some DME may require precertification by you or your physician.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> 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 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by your attending physician and provided by nurses and home health aides. Your attending physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications. <p>Note: Home health services must be precertified by your attending Physician.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family.</i> • <i>Transportation</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> • <i>Services of a social worker</i> • <i>Services provided by a family member or resident in the member's home.</i> • <i>Services rendered at any site other than the member's home.</i> 	<p><i>All charges</i></p>
Chiropractic	
<p><i>No benefits</i></p>	<p><i>All charges</i></p>
Alternative treatments	
<p><i>No benefits</i></p>	<p><i>All charges</i></p>
Educational classes and programs	
<p>We offer the following Aetna disease management programs at no cost to you:</p> <ul style="list-style-type: none"> • Congestive heart failure • Coronary artery disease • Diabetes • Asthma <p>To request more information on our disease management programs, call 1-800/537-9384.</p>	<p>Nothing</p>

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - \$1,500 for Self Only enrollment and \$3,000 for Self & Family enrollment or Out-of-Network - \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by 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.).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible...
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible...
Surgical procedures (cont.)	
<ul style="list-style-type: none"> Surgical treatment of morbid obesity (bariatric surgery) – a condition that has persisted for at least 5 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) – <i>Orthopedic and prosthetic devices</i> for device coverage information <p>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.</p> <ul style="list-style-type: none"> Voluntary sterilization (e.g., tubal ligation, vasectomy) Treatment of burns Skin grafting and tissue implants 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgically-induced sterilization</i> <i>Surgery primarily for cosmetic purposes</i> <i>Radial keratotomy and laser surgery, including related procedures designed to surgically correct refractive errors</i> <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> Surgery to correct a functional defect Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member’s appearance and - the condition can reasonably be expected to be corrected by such surgery 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Reconstructive surgery - continued on next page

Benefit Description	You pay After the calendar year deductible...
Reconstructive surgery (cont.)	
<ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (<i>see Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, that are medical in nature, such as:</p> <ul style="list-style-type: none"> • Treatment of fractures of the jaws or facial bones; • Removal of stones from salivary ducts; • Excision of benign or malignant lesions; • Medically necessary surgical treatment of TMJ (must be preauthorized); and • Excision of tumors and cysts. <p>Note: When requesting oral and maxillofacial services, please check DocFind or call Member Services at 1-800/537-9384 for a participating oral and maxillofacial surgeon.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Dental implants</i> • <i>Dental care (such as restorations) involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i> 	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants	
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>National Transplant Program (NTP)</i> on page 97 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description and can safely tolerate the procedure.</p> <ul style="list-style-type: none"> • 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 <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced forms of myelodysplastic syndromes - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolysaccharidosis (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 - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer* - Epithelial ovarian cancer* - Amyloidosis - Ependyoblastoma* - Ewing’s sarcoma - Medulloblastoma - Pineoblastoma* <p>* Approved clinical trial necessary for coverage</p>	<p>In network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>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:</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma • Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Advanced forms of 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 - Multiple myeloma - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma* - Sarcomas* <p>* Approved clinical trial necessary for coverage</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> • Autologous transplants for <ul style="list-style-type: none"> - Chronic lymphocytic leukemia* - Chronic myelogenous leukemia* - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma* - Multiple sclerosis* - Systemic lupus erythematosus* - Systemic sclerosis* <p>* Approved clinical trial necessary for coverage</p> <p>• National Transplant Program (NTP) – Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your attending doctor and plan specialist and approved by our medical director in advance of the surgery. To receive in-network benefits, the transplant must be performed at hospitals (Institutes of Excellence) specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor until discharge from the hospitalization where the donation occurred, to the extent these services are not covered by another plan or program.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<p>Note: An accepted donor is covered for evaluations and for medical expenses incurred only during the donation hospitalization.</p> <p>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</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Clinical trials must meet the following criteria:</p> <p>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</p> <p>B. <i>All</i> of the following criteria must be met:</p> <ol style="list-style-type: none"> 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: <ol style="list-style-type: none"> a. The experimental or investigational drug, device, procedure, or treatment is under current review by the FDA and has an Investigational New Drug (IND) number; and b. The clinical trial has passed review by a panel of independent medical professionals (evidenced by Aetna’s review of the written clinical trial protocols from the requesting institution) approved by Aetna who treat the type of disease involved and has also been approved by an Institutional Review Board (IRB) that will oversee the investigation; and c. The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national cooperative body (e.g., Department of Defense, VA Affairs) and conforms to the rigorous independent oversight criteria as defined by the NCI for the performance of clinical trials; and d. The clinical trial is not a single institution or investigator study (NCI designated Cancer Centers are exempt from this requirement); and 4. The member must: <ol style="list-style-type: none"> a. Not be treated “off protocol;” and b. Must actually be enrolled in the trial. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Section 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.
- The deductible is: In-network - \$1,500 for Self Only enrollment and \$3,000 for Self & Family enrollment or Out-of-Network - \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR NETWORK PHYSICIAN MUST PRECERTIFY HOSPITAL STAYS FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL STAYS FOR NON-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY FOR NON-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital	
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p> <ul style="list-style-type: none"> • 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 prolactin • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Benefit Description	You Pay After the calendar year deductible...
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Whole blood and concentrated red blood cells not replaced by the member</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Custodial care, rest cures, domiciliary or convalescent cares</i> • <i>Personal comfort items, such as a telephone, television, barber service, guest meals and beds</i> • <i>Private nursing care</i> 	<p><i>All charges</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Radiologic procedures, diagnostic laboratory tests, and X-rays when associated with a medical procedure being done the same day • Pathology Services • Administration of blood, blood plasma, and other biologicals • Blood products, derivatives and components, artificial blood products and biological serum • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Whole blood and concentrated red blood cells not replaced by the member.</i></p>	<p><i>All charges</i></p>
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 60-day limit per calendar year when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All charges</i></p>

Benefit Description	You Pay After the calendar year deductible...
Hospice care	
<p>Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of your attending Physician, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less. We allow up to a maximum of \$5,000 for outpatient hospice services and a period not to exceed 30 days for inpatient hospice services.</p> <p>Note: Inpatient hospice services require prior approval.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
Ambulance	
<p>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:</p> <ol style="list-style-type: none"> 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. 	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency .</i> • <i>Ambulette service</i> 	<p><i>All charges</i></p>

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - \$1,500 for Self Only enrollment and \$3,000 for Self & Family enrollment or Out-of-Network - \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

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

Benefit Description	You pay After the calendar year deductible...
<p>Emergency</p> <ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an out patient in a hospital, including doctors' services 	<p>In-network or out-of-network: 10% of our Plan allowance</p>
<p><i>Not covered: Elective or non-emergency care</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay After the calendar year deductible...
Ambulance	
<p>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:</p> <ol style="list-style-type: none"> 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. <p>Note: Air ambulance may be covered. Prior approval is required.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Ambulance transportation to receive outpatient or inpatient services and back home again, except in an emergency.</i> • <i>Ambulette service.</i> • <i>Air ambulance without prior approval.</i> 	<p><i>All charges</i></p>

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible is: In-network - \$1,500 for Self Only enrollment and \$3,000 for Self & Family enrollment or Out-of-Network - \$2,500 for Self Only enrollment and \$5,000 for Self & Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- **Some services must be preauthorized.** We may limit your benefits if you do not obtain a treatment plan for inpatient care.

Benefit Description	You pay After the calendar year deductible...
<p>Mental health and substance abuse benefits</p> <p>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.</p> <p>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.</p> <p>Outpatient services include:</p> <ul style="list-style-type: none"> • Individual and group therapy performed by licensed providers such as psychiatrists, psychologists, or clinical social workers • Facility based intensive outpatient or partial hospital treatment programs • Outpatient services provided by a hospital or other facility • Diagnostic tests • Medication management <p>Inpatient care includes:</p> <ul style="list-style-type: none"> • Both mental health and chemical dependency services provided by an appropriately licensed inpatient facility including licensed residential treatment facilities <p>Note: All inpatient services are subject to precertification. Please call Member Services at 1-800/537-9384 for more information.</p>	<p>In-network: 10% of our Plan allowance</p> <p>Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.</p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Mental health and substance abuse benefits (cont.)	
<p>Note: OPM will base its review of disputes about treatment plans on the treatment plan’s clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</p>	
<i>Not covered: Services we have not approved.</i>	<i>All charges</i>

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. Precertification is 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.

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. Copayment levels reflect in-network pharmacies only. If you obtain your prescription at an out-of-network pharmacy (non-preferred), you will be reimbursed at our Plan allowance less 40%. You are responsible for any difference between our Plan allowance and the billed amount.
- 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.
- For prescription drugs and medications, you first must satisfy your deductible: In-network: \$1,500 for Self Only enrollment and \$3,000 for Self & Family enrollment or Out-of-Network \$2,500 for Self Only enrollment and \$5,000 for Self and Family enrollment each calendar year. The Self and Family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this Section and is reduced by your HRA Fund, if applicable. While you are meeting this deductible, the cost of your prescriptions will automatically be deducted from your HRA Fund at the time of the purchase. If you are enrolled in the HSA, you will be responsible for the cost of the prescription. You may use your HSA debit card. The cost of your prescription is based on the Aetna contracted rate with network pharmacies. The Aetna contracted rate with the network pharmacy does not reflect or include any rebates Aetna receives from drug manufacturers.
- Once you satisfy the deductible, you will then pay a copayment at in-network retail pharmacies or the mail-order pharmacy for prescriptions under your Traditional medical coverage. You will pay 30% coinsurance plus the difference between our Plan allowance and the billed amount at out-of-network retail pharmacies. There is no out-of-network mail order pharmacy program.
- 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.
- 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.

There are important features you should be aware of which include:

- **Who can write your prescription.** A licensed physician, dentist or licensed practitioner (as allowed by law) must write the prescription.
- **Where you can obtain them.** Any retail pharmacy can be used for up to a 30-day supply. Our mail order program can be utilized for a 31-day up to a 90-day supply of medication (if authorized by your physician). You may obtain up to a 30-day supply of medication for one copay (retail pharmacy), and for a 31-day up to a 90-day supply of medication for two copays (mail order). For retail pharmacy transactions, you must present your Aetna Member ID card at the point of sale for coverage. Please call Member Services at 1-800/537-9384 for more details on how to use the mail order program. If accessing a nonparticipating pharmacy, the member must pay the full cost of the medication at the point of service, then submit a complete paper claim and a receipt for the cost of the prescription to our Direct Member Reimbursement (DMR) unit. Reimbursements are subject to review to determine if the claim meets applicable requirements, and are subject to the terms and conditions of the benefit plan and applicable law.
- **We use a formulary.** Drugs are prescribed by attending licensed doctors and covered in accordance with the Plan’s drug formulary; however, coverage is not limited to medications included on the formulary. Many non-formulary drugs are also covered but a higher copayment will apply. Certain drugs require your doctor to get precertification from the Plan before they can be covered under the Plan. Visit our Web site at www.aetnafeds.com to review our Formulary Guide or call 1-800/537-9384.

Prescription drug benefits continued on next page

- **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.
- **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
- **When to use a participating retail or mail order pharmacy.** Covered prescription drugs prescribed by a licensed physician or dentist and obtained at a participating Plan retail pharmacy may be dispensed for up to a 30-day supply. Members must obtain a 31-day up to a 90-day supply of covered prescription medication through mail order. In no event will the copay exceed the cost of the prescription drug. A generic equivalent will be dispensed if available, unless your physician specifically requires a brand name. Drug costs are calculated based on Aetna's contracted rate with the network pharmacy excluding any drug rebates.

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

Aetna allows coverage of a medication filling when at least 75% of the previous prescription according to the physician's prescribed directions, has been utilized. For a 30-day supply of medication, this provision would allow a new prescription to be covered on the 23rd day, thereby allowing a member to have an additional supply of their medication, in case of emergency.

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic

- **Why use generic drugs?** Generics contain the same active ingredients in the same amounts as their brand name counterparts and have been approved by the FDA. By using generic drugs, when available, most members see cost savings, without jeopardizing clinical outcome or compromising quality.
 - **When you do have to file a claim.** Send your itemized bill(s) to: Aetna, Pharmacy Management, Claim Processing, P.O. Box 14024, Lexington, KY 40512-4024.
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Prescription drug benefits begin on next page

Benefit Description	You pay After the calendar year deductible...
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by your licensed attending physician or dentist and obtained from a Plan pharmacy or through our mail order program or an out-of-network retail pharmacy:</p> <ul style="list-style-type: none"> • Drugs and medicines approved by the U.S. Food and Drug Administration for which a prescription is required by Federal law, except those listed as <i>Not Covered</i> • Self-injectable drugs • Contraceptive drugs and devices • Oral fertility drugs • Diabetic supplies limited to lancets, alcohol swabs, urine test strips/ tablets, and blood glucose test strips • Insulin • Disposable needles and syringes for the administration of covered medications 	<p>In-network:</p> <p>The full cost of the prescription is applied to the deductible before any benefits are considered for payment under the pharmacy plan. Once the deductible is satisfied, the following will apply:</p> <p>Retail Pharmacy, for up to a 30-day supply per prescription or refill:</p> <p>\$10 per covered generic formulary drug;</p> <p>\$25 per covered brand name formulary drug; and</p> <p>\$40 per covered non-formulary (generic or brand name) drug.</p> <p>Mail Order Pharmacy, for a 31-day up to a 90-day supply per prescription or refill:</p> <p>\$20 per covered generic formulary drug</p> <p>\$50 per covered brand name formulary drug; and</p> <p>\$80 per covered non-formulary (generic or brand name) drug.</p> <p>Out-of-network (retail pharmacies only):</p> <p>30% plus the difference between our Plan allowance and the billed amount.</p>
<p>Limited benefits:</p> <ul style="list-style-type: none"> • Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits 	<p>In-network:</p> <p>50%</p>
<ul style="list-style-type: none"> • Imitrex (limited to 48 kits per calendar year) 	<p>\$25/kit</p>
<ul style="list-style-type: none"> • Depo-Provera is limited to 5 vials per calendar year 	<p>\$25 copay per vial</p>
<ul style="list-style-type: none"> • One diaphragm per calendar year 	<p>\$25 per diaphragm</p>
	<p>Out-of-network (retail pharmacies only):</p> <p>30% plus the difference between our Plan allowance and the billed amount, except for drugs to treat sexual dysfunction which are 50% plus the difference between our Plan allowance and the billed amount.</p>

Covered medications and supplies continued on next page

Benefit Description	You pay After the calendar year deductible....
Covered medications and supplies (cont.)	

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 members’ medical benefits, are now covered under their Aetna 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-Monoclonal 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 2008 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 at www.aetnafeds.com for current Medication

Benefit Description	You pay... After the calendar year deductible...
Covered medications and supplies (cont.)	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs used for the purpose of weight reduction, such as appetite suppressants</i> • <i>Drugs for cosmetic purposes, such as Rogaine</i> • <i>Drugs to enhance athletic performance</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over-the-counter (OTC) drug)</i> • <i>Lost, stolen or damaged drugs</i> • <i>Vitamins, nutritional and dietary substances/supplements that can be purchased without prescription</i> • <i>Smoking cessation drugs and medication including, but not limited to, nicotine patches and sprays</i> • <i>Prophylactic drugs including, but not limited to, anti-malarials for travel</i> 	<p><i>All charges</i></p>

Section 5(g). Special features

Feature	Description
<p>Aetna IntelliHealth®</p>	<p>Aetna IntelliHealth.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 Aetna IntelliHealth to provide trusted and credible health information to its users. Aetna IntelliHealth features include: a Drug Resource Center, Disease and Condition Management tools, the Harvard Symptom Scout (an interactive symptom checker that provides guidance about a variety of symptoms), Daily Health News and much more. Visit Aetna IntelliHealth at www.aetnafeds.com.</p>
<p>Aetna Navigator™</p>	<p>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.</p> <p>With Aetna Navigator, you can:</p> <ul style="list-style-type: none"> • 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 Intellihealth and Healthwise® Knowledgebase • Check HSA balances <p>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.</p>
<p>Informed Health® Line</p>	<p>Provides eligible members with telephone access to registered nurses experienced in providing information on a variety of health topics. Informed Health Line is available 24 hours a day, 7 days a week. You may call Informed Health Line at 1-800/556-1555. Through Informed Health Line, members also have 24-hour access to an audio health library – equipped with information on more than 2,000 health topics, and accessible on demand through any touch tone telephone. Topics are available in both English and Spanish. We provide TDD service for the hearing and speech-impaired. We also offer foreign language translation for non-English speaking members. Informed Health Line nurses cannot diagnose, prescribe medication or give medical advice.</p>
<p>Services for the deaf and hearing-impaired</p>	<p>1-800/628-3323</p>

Section 5(h). Health education resources and account management tools

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

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 member responsibility, 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 VisionSM 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 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.

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.

Fitness Program

Aetna offers members access to discounted fitness services provided by GlobalFitTM. 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 (not available in Alaska). Additionally, the program helps members save on nontraditional services they may already use. With the Natural Products and Services 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 pages 19-20.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Procedures, services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies 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

Medical, hospital, and drug benefits

To obtain claim forms or other claims filing advice or answers about your benefits, contact us at 1-800/537-9384.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800/537-9384.

When you must file a claim, such as when you use non-network providers, for services you receive overseas or when another group health plan is primary, submit it on the Aetna claim form. You can obtain this form by either calling us at 1-800/537-9384 or by logging onto your personalized home page on Aetna Navigator from the www.aetnafeds.com Web site and clicking on "Forms." Bills and receipts should be itemized and show:

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

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

In addition:

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

Records

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

Deadline for filing your claim

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

**Consumer Driven Health Plan(CDHP)/Health Reimbursement Arrangement(HRA)/
High Deducible Health Plan (HDHP)**

Aetna Life Insurance Company
P.O. Box 14089
Lexington, KY 40512-4089

Any withdrawals from your HSA must be done via your debit card, check, or Auto-Debit.

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

Overseas claims

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

Aetna Life Insurance Company
P.O. Box 14089
Lexington, KY 40512-4089

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, Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Aetna Inc., Attention: National Accounts, P.O. Box 14463, Lexington, KY 40512; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> 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	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within</p> <ul style="list-style-type: none"> • 90 days after the date of our letter upholding our initial decision; 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call.

Step	Description
	<p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <p>Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
5	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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 have coverage under any other health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; 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. Your care must continue to be authorized or precertified as required. Also, please note that if your attending physician does not participate in Medicare, you will have to file a claim with Medicare.

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. **We do not waive cost-sharing for your FEHB coverage.** For more information, please call us at 1-888/788-0390.

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, coinsurance, member responsibility (CDHP) or deductible (HDHP). 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.

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

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

**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.
Catastrophic Protection	<p>When you use network providers, your annual maximum for out-of-pocket expenses (member responsibility, deductibles, coinsurance, and copayments) for covered services is limited to the following:</p> <p>CDHP</p> <p>Self Only:</p> <p>In-network: Your annual out-of-pocket maximum is \$3,000.</p> <p>Out-of-network: Your annual out-of-pocket maximum is \$4,000.</p> <p>Self and Family:</p> <p>In-network: Your annual out-of-pocket maximum is \$6,000.</p> <p>Out-of-network: Your annual out-of-pocket maximum is \$8,000.</p> <p>HDHP</p> <p>Self Only:</p> <p>In-network: Your annual out-of-pocket maximum is \$4,000.</p> <p>Out of-network: Your annual out-of-pocket maximum is \$5,000.</p> <p>Self and Family:</p> <p>In-network: Your annual out-of-pocket maximum is \$8,000.</p> <p>Out of-network: Your annual out-of-pocket maximum is \$10,000.</p> <p>However, certain expenses under both options do not count towards your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum. Refer to Section 4.</p>
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 21.
Copayment	A copayment is the fixed amount of money you pay when you receive covered services. See page 21.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.

Custodial care	Any type of care provided according to Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; or c) is a level such that you have reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Custodial care includes any type of care where the primary purpose is to attend to your daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples include assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of noninfected wounds, post-operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by you, the general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in our sole determination, is based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, or convalescent care. Custodial care that lasts 90 days or more is sometimes known as long term care. Custodial care is not covered.
Deductible	A deductible is the fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.
Detoxification	The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.
Emergency care	An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.
Experimental or investigational services	<p>Services or supplies that are, as determined by us, experimental. A drug, device, procedure or treatment will be determined to be experimental if:</p> <ul style="list-style-type: none"> • There is not sufficient outcome data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or • Required FDA approval has not been granted for marketing; or • A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or for research purposes; or • The written protocol or protocol(s) used by the treating facility or the protocol or protocol(s) of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental or for research purposes; or • It is not of proven benefit for the specific diagnosis or treatment of your particular condition; or • It is not generally recognized by the Medical Community as effective or appropriate for the specific diagnosis or treatment of your particular condition; or • It is provided or performed in special settings for research purposes.

Member responsibility Member responsibility is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying Traditional benefits for those services. Medical Fund dollars that you have rolled over from previous years in the CDHP plan can be used to help you meet your member responsibility.

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.

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

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

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

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

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

Preventive care Health care services designed for prevention and early detection of illnesses in average risk people, generally including routine physical examinations, tests and immunizations.

Respite care	Care furnished during a period of time when your family or usual caretaker cannot, or will not, attend to your needs. Respite care is not covered.
Rollover	Any unused, remaining balance in your CDHP Medical Fund or Dental Fund or your HDHP HSA/HRA at the end of the calendar year may be rolled over to subsequent years.
Urgent care	Covered benefits required in order to prevent serious deterioration of your health that results from an unforeseen illness or injury if you are temporarily absent from our service area and receipt of the health care service cannot be delayed until your return to our service area.
Us/We	Us and we refer to Aetna Life Insurance Company.
You	You refers to the enrollee and each covered family member.

Consumer Driven Health Plan (CDHP) Definitions

Consumer Driven Health Plan	A network provider plan under the FEHB that offers you greater control over choices of your health care expenditures.
Dental Fund (Consumer Driven Health Plan)	Your Dental Fund is an established benefit amount which is available for you to use to pay for covered dental expenses. You determine how your Dental Fund will be spent and any unused amount at the end of the year will be rolled over in subsequent year(s).
Medical Fund (Consumer Driven Health Plan)	Your Medical Fund is an established benefit amount which is available for you to use to pay for covered hospital, medical and pharmacy expenses. Once you have used \$1,250 for Self Only or \$2,500 for Self and Family enrollment of your annual Medical Fund, and have satisfied your member responsibility, Traditional medical coverage begins. Excess funds in your Medical Fund from prior year rollovers will be used to help you meet your member responsibility.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible	Your calendar year deductible is \$1,500 for Self only or \$3,000 for Self and Family enrollment for In-Network services OR \$2,500 for Self only or \$5,000 for Self and Family enrollment for Out-of-Network services.
Health Savings Account (HSA)	An HSA is a special, tax-advantaged account where money goes in tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for qualified medical services.
Health Reimbursement Arrangement (HRA)	An HRA combines a Fund with a deductible-based medical plan with coinsurance limits. The HRA Fund pays first. Once you exhaust your HRA Fund, Traditional medical coverage begins after you satisfy your deductible. Your HRA Fund counts toward your deductible.
High Deductible Health Plan (HDHP)	An HDHP is a plan with a deductible of at least \$1,100 for individuals and \$2,200 for families for 2008, adjusted each year for cost of living.
Maximum HSA Contribution	For 2008, the annual statutory maximum contribution is \$2,900 for Self Only enrollment and \$5,800 for Self & Family enrollment.
Catch-Up HSA Contribution	For 2008, individuals age 55 or older may make a catch up contribution of \$900.
Premium Contribution to HSA/HRA	The amount of money we contribute to your HSA on a monthly basis. In 2008, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA \$62.50 per month for Self Only and \$125 per month for Self and Family. If you have the HRA, and are a current member or enrolled during Open Season, we contribute \$750 for Self only or \$1,500 for Self and Family enrollments at the beginning of the year. If you enroll after January 1, 2008, the amount contributed will be on a prorated basis.

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;
- 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 2008 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 2007 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 temporary 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 to 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 Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

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

Third, 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 qualified dependents.

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). 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.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. **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)** – Pays 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)** – Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependents unable to care for themselves that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

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 has 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. Premiums are withheld from salary on a pre-tax basis.
Dental Insurance	Dental plans provide a comprehensive range of services, including all of the following: <ul style="list-style-type: none">• 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).

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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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Prescription drugs...60-63, 100, 106-109, 138-141
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Notes

Notes

Summary of benefits for the CDHP of the Aetna HealthFund Plan-2008

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- For the Consumer Driven Health Plan (CDHP), your health charges are applied to your annual Medical Fund, \$1,250 for Self Only and \$2,500 for Self and Family. Once your annual Medical Fund has been exhausted, you must satisfy your calendar year member responsibility, \$750 for Self Only and \$1,500 for Self and Family. Any Medical Fund dollars that you have rolled over from previous years in the CDHP plan will help you meet your member responsibility. You pay any difference between our allowance and the billed amount if you use a non-network physician or other health care professional. Once your calendar year member responsibility is satisfied, Traditional medical coverage begins.

CDHP Benefits	You Pay	Page
In-network medical and dental preventive care	Nothing at a network provider	29
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In-network: 10% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	38
Services provided by a hospital:		
• Inpatient	In-network: 10% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	53
• Outpatient	In-network: 10% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	54
Emergency benefits:	In-network or out-of-network: 10% of our Plan allowance	56
Mental health and substance abuse treatment:	In-network: 10% of our Plan allowance Out-of-network: 40% of our Plan allowance and any difference between our allowance and the billed amount.	58
Prescription drugs:		
• After your member responsibility has been satisfied, your copayment will apply.		60
• Retail pharmacy	In-network: For up to a 30-day supply: \$10 per generic formulary; \$25 per brand name formulary; and \$40 per nonformulary (generic or brand name)	61

Summary of benefits continued on next page

CDHP Benefits (cont.)	You Pay	Page
<ul style="list-style-type: none"> Retail pharmacy (continued) 	Out-of-network (retail pharmacy only): 40% plus the difference between our Plan allowance and the billed amount.	62
<ul style="list-style-type: none"> Mail order (available in-network only) 	For a 31-day up to a 90-day supply: Two copays	62
Dental care: Dental Fund of \$300 for Self Only or \$600 for Self and Family	In-network: After your Dental Fund has been exhausted, the negotiated rates offered by participating network PPO dentists. Out-of-network: After your Dental Fund has been exhausted, all charges.	35
Vision care: In-network (only) preventive care benefits.	Nothing	30
Special features: Aetna IntelliHealth, Aetna Navigator, Informed Health Line, and Services for the deaf and hearing-impaired	Contract Plan	64
Protection against catastrophic costs (out-of-pocket maximum):	In-network: Nothing after \$3,000/Self Only or \$6,000/Self and Family enrollment per year. Out-of-network: Nothing after \$4,000/Self Only or \$8,000/Self and Family enrollment per year. Some costs do not count toward this protection. Your member responsibility counts toward your out-of-pocket maximum.	22

Summary of benefits for the HDHP of the Aetna HealthFund Plan-2008

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- In 2008, for each month you are eligible for the HSA, Aetna will deposit \$62.50 per month for Self Only enrollment or \$125 per month for Self and Family enrollment to your HSA. For the Health Savings Account (HSA), you first must satisfy your calendar year deductible: In-network: \$1,500 for Self Only enrollment and \$3,000 for Self & Family enrollment or Out-of-Network \$2,500 for Self Only and \$5,000 for Self and Family by using your HSA or by paying out-of-pocket. Once your calendar year deductible is satisfied, Traditional medical coverage begins.
- For the Health Reimbursement Arrangement (HRA), your health charges are applied first to your HRA Fund of \$750 for Self Only and \$1,500 for Self and Family. Once your HRA is exhausted, and applied toward reducing your calendar year deductible, you must pay out-of-pocket to satisfy the remainder of your calendar year deductible. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

HDHP Benefits	You Pay	Page
In-network medical and dental preventive care	Nothing at a network provider	79
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	84
Services provided by a hospital:		
• Inpatient	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	99
• Outpatient	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	100
Emergency benefits:	In-network or out-of-network: 10% of our Plan allowance	102
Mental health and substance abuse treatment:	In-network: 10% of our Plan allowance Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.	104
Prescription drugs:		106
• After your deductible has been satisfied, your copayment will apply.		

Summary of benefits continued on next page

HDHP Benefits (cont.)	You Pay	Page
<ul style="list-style-type: none"> Retail pharmacy 	<p>In-network: For up to a 30-day supply; \$10 per generic formulary; \$25 per brand name formulary; and \$40 per nonformulary (generic or brand name)</p> <p>Out-of-network (retail pharmacy only): 30% plus the difference between our Plan allowance and the billed amount.</p>	108
<ul style="list-style-type: none"> Mail order (available in-network only) 	For a 31-day up to a 90-day supply: Two copays	108
Dental care:	No benefit other than in-network dental preventive care.	82
Vision care: In-network (only) preventive care benefits. \$100 reimbursement for eyeglasses or contact lenses every 24 months.	Nothing	80
Special features: Aetna IntelliHealth, Aetna Navigator, Informed Health Line, and Services for the deaf and hearing-impaired	Contact Plan	110
Protection against catastrophic costs (out-of-pocket maximum):	<p>In-network: Nothing after \$4,000/Self Only or \$8,000/Self and Family enrollment per year.</p> <p>Out-of-network: Nothing after \$5,000/Self Only or \$10,000/Self and Family enrollment per year.</p> <p>Some costs do not count toward this protection. Your deductible counts toward your out-of-pocket maximum.</p>	23

2008 Rate Information for the Aetna HealthFund 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 Category 1 rates apply to certain career non-law enforcement Postal Service employees. **Postal Category 2 rates** apply to other career non-law enforcement Postal Service employees. *PostalEASE*, the employee self-service system used for FEHB enrollment, automatically provides the applicable premium to individual employees. Career non-law enforcement employees may also refer to the *Guide to Federal Benefits for United States Postal Service Employees, RI 70-2*, to determine their rates.

Different rates apply and a special Guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

For further assistance, Postal Service employees should call:

Human Resources Shared Service Center
1-877-477-3273, Option 5
TTY: 1-866-260-7507

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	Category 1 Your Share	Category 2 Your Share
CDHP Option Self Only	221	\$113.63	\$37.87	\$246.19	\$82.06	\$18.94	\$17.04
CDHP Option Self and Family	222	\$261.35	\$87.11	\$566.25	\$188.75	\$43.56	\$39.20
HDHP Option Self Only	224	\$92.77	\$30.92	\$201.00	\$67.00	\$15.46	\$13.92
HDHP Option Self and Family	225	\$203.15	\$67.72	\$440.17	\$146.72	\$33.86	\$30.47