Aetna U.S. Healthcare® 2001

http://www.aetnaushc.com/feds.

A Health Maintenance Organization

Enrollment in this Plan is limited; see page 8 for requirements.

Serving: Southwestern, Central and Northeastern Pennsylvania

Enrollment code:

- **KL1 High Option Self Only**
- **KL2 High Option Self and Family**
- **KL4 Standard Option Self Only**
- **KL5 Standard Option Self and Family**

Serving: Southeastern Pennsylvania and Delaware

Enrollment code:

- **SU1 High Option Self Only**
- **SU2 High Option Self and Family**
- **SU4 Standard Option Self Only**
- **SU5 Standard Option Self and Family**

Special Notice
This brochure includes benefits for Prudential HealthCare members transferred to Aetna U.S. Healthcare

Serving: New Jersey

Enrollment code:

- **P31 High Option Self Only**
- **P32 High Option Self and Family**
- **P34 Standard Option Self Only**
- **P35 Standard Option Self and Family**

Serving: All of Washington, DC, North and Central Maryland and Northern Virginia

Enrollment code:

- **JN1 High Option Self Only**
- **JN2 High Option Self and Family**
- **JN4 Standard Option Self Only**
- **JN5 Standard Option Self and Family**

Serving: All of Central, Richmond and Tri-Cities Virginia

Enrollment code:

- **XE1 High Option Self Only**
- **XE2 High Option Self and Family**
- **XE4 Standard Option Self Only**
- **XE5 Standard Option Self and Family**

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UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

Federal Employees
Health Benefits Program

RI 73-052

Table of Contents

Introduction

Aetna U.S. Healthcare, Inc.
1425 Union Meeting Road
P.O. Box 1126, Mail Stop U32A
Blue Bell, PA 19422

This brochure describes the benefits you can receive from Aetna U.S. Healthcare under our contract (CS 1766) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for 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, 2001, unless these benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 10. Rates are shown at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Aetna U.S. Healthcare.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at **www.opm.gov/insure** or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

How we pay providers

- **Provider Compensation**

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

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

Plan providers in our network have agreed to be compensated in various ways. Many participating primary care physicians (PCPs) are paid by capitation. Under capitation, a physician receives payment for a patient whether the physician sees the patient that month or not.

Specialists, hospitals, primary care physicians and other providers in the Aetna U.S. Healthcare network may also be paid in the following ways:

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

You are encouraged to ask your physicians and other providers how they are compensated for their services, including whether their specific arrangements include any financial incentives to control costs.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, which allows you to get information about your health plan, its networks, providers, and facilities. OPM's FEHB website (**www.opm.gov/insure**) lists the specific types of information that we must make available to you. Some of the required information is listed below.

Medical Necessity

Covered services include most types of treatment by PCPs, specialists and hospitals. However, the health plan also excludes or limits coverage for some services, including but not limited to cosmetic surgery and experimental procedures. In addition, in order to be covered, all services, including the location (type of facility), duration and costs of services, must be medically necessary as defined in this Plan and as determined by us. (See definition on page 55).

Direct Access Ob/Gyn Program

This program allows female members to visit any participating gynecologist for a routine well-woman exam, including a Pap smear (if appropriate) and an unlimited number of visits for gynecologic problems and follow-up care as described in your benefits plan. Gynecologists may also refer a woman directly for covered gynecologic services without the patient's having to go back to her participating primary care physician. If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG) or a similar organization, covered care must be coordinated through the IPA, the PMG or the similar organization.

Mental Health/Substance Abuse

In most areas, certain behavioral health care services (e.g., treatment or care for mental disease or illness, alcohol abuse and/or substance abuse) are managed by an independently contracted organization. This organization makes initial coverage determinations and coordinates referrals; any behavioral health care referrals will generally be made to providers affiliated with the organization, unless your needs for covered services extend beyond the capability of the affiliated providers. 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. As with other coverage determinations, you may appeal behavioral health care coverage decisions in accordance with the provisions of your Plan.

Ongoing Reviews

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

Authorization

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

Patient Management

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

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

Our patient management staff uses national guidelines and resources to guide the precertification, concurrent review and retrospective review processes. Using the information obtained from providers, patient management staff utilize Milliman & Robertson Health Care Management Guidelines when conducting concurrent review. If there is no applicable Milliman & Robertson Guideline, patient management staff utilizes InterQual ISD criteria. When applicable, Medicare National Coverage Decisions are followed for Medicare Managed Care members. To the extent certain 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**	Certain health care services, such as hospitalization or outpatient surgery, require precertification by us to ensure coverage for those services. When a member is to obtain services requiring precertification through a Plan provider, this provider should precertify those services prior to treatment.
• **Concurrent Review**	The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require Concurrent Review.
• **Discharge Planning**	Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.
• **Retrospective Record Review**	The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of health care services. Our effort to manage the services provided to members includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

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

- Ask questions about benefits and coverage.
- Notify us of changes in your name, address or telephone number.
- Change your primary care physician or office.
- Obtain information about how to file a grievance.

Confidentiality
We protect the privacy of confidential Plan member medical information. We contractually require that participating providers keep member information confidential in accordance with applicable laws. Furthermore, you have the right to access your medical records from participating providers, at any time. Aetna U.S. Healthcare (including its affiliates and authorized agents, collectively "Aetna U.S. Healthcare") and participating providers require access to member medical information for a number of important and appropriate purposes, including claims payment, fraud prevention, coordination of care, data collection, performance measurement, fulfilling state and federal requirements, quality management, utilization review, research and accreditation activities, preventive health, early detection and disease management programs. Accordingly, for these purposes, members authorize the sharing of member medical information about themselves and their dependents between Aetna U.S. Healthcare and Plan providers and health delivery systems.

If you want more information about us, call 1-800-537-9384, or write to 1425 Union Meeting Road, P.O. Box 1126, Mail Stop U32A, Blue Bell, PA 19422. You may also contact us by fax at 215-775-6550 or visit our website at **www.aetnaushc.com/feds**.

Service Area

What is this Plan's service area?

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is:

Pennsylvania

4/00
This service has Commendable accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

Serving: Southwestern, Central and Northeastern Pennsylvania

Enrollment Code:

KL1 High Option Self Only
KL2 High Option Self and Family
KL4 Standard Option Self Only
KL5 Standard Option Self and Family

Adams, Allegheny, Armstrong, Beaver, Blair, Bradford, Butler, Cambria, Carbon, Clarion, Clinton, Columbia, Cumberland, Dauphin, Erie, Fayette, Franklin, Fulton, Greene, Jefferson, Lawrence, Lackawanna, Lancaster, Lebanon, Luzerne, Lycoming, Mercer, Monroe, Northumberland, Perry, Pike, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Washington, Wayne, Westmoreland, Wyoming and York counties

12/99
This service has Excellent accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

Serving: Southeastern Pennsylvania

Enrollment Code:

SU1 High Option Self Only
SU2 High Option Self and Family
SU4 Standard Option Self Only
SU5 Standard Option Self and Family

Berks, Bucks, Chester, Delaware, Lehigh, Montgomery, and Northampton counties and Philadelphia

Delaware

5/98
This service has Excellent accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

Serving: All of Delaware

Enrollment Code:

SU1 High Option Self Only
SU2 High Option Self and Family
SU4 Standard Option Self Only
SU5 Standard Option Self and Family

The State of Delaware

New Jersey

5/98
This service has Commendable accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

Serving: All of New Jersey

Enrollment Code:

P31 High Option Self Only
P32 High Option Self and Family
P34 Standard Option Self Only
P35 Standard Option Self and Family

The State of New Jersey

Maryland/DC/ Northern Virginia

3/99

This service has Commendable accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

Serving: All of Washington, DC, North and Central Maryland and Northern Virginia

Enrollment Code:

JN1 High Option Self Only
JN2 High Option Self and Family
JN4 Standard Option Self Only
JN5 Standard Option Self and Family

All of Washington, DC; the Maryland counties of Anne Arundel, Baltimore, Baltimore City, Calvert, Carroll, Cecil, Charles, Frederick, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's, St. Mary's, Talbot, Washington, Wicomico and Worcester; The Virginia counties of Arlington, Caroline, Fairfax, Fauquier, King George, Loudon, Louisa, Prince William, Spotsylvania, Stafford and Westmoreland; plus the cities of Alexandria, Fairfax, Falls Church, Fredericksburg, Manassas and Manassas Park.

Central, Richmond and Tri-Cities Virginia

Serving: Central, Richmond and Tri-Cities Virginia

Enrollment Code:

XE1 High Option Self Only
XE2 High Option Self and Family
XE4 Standard Option Self Only
XE5 Standard Option Self and Family

The Virginia Counties of: Charles, Chesterfield, Colonial Heights, Dinwiddie, Goochland, Hanover, Henrico, Hopewell, King William, New Kent, Nottaway, Petersburg, Powhattan, Richmond.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, higher cost sharing and shorter day limitations were placed on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Customer Service at 1-800-537-9384, **or** checking our website at **www.aetnaushc.com/feds.** You can find out more about patient safety on the OPM website, **www.opm.gov/insure**. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- If your are enrolled in Prudential Healthcare HMO Mid-Atlantic enrollment Code JB in Maryland, Northern Virginia, and Washington, DC your enrollment will automatically be transferred into Aetna U.S. Healthcare enrollment Code JN, High Option. However, you may change to a Standard Option enrollment during Open Season. Please review this brochure for your benefits.
- If your are enrolled in Prudential Healthcare HMO New Jersey enrollment Code 8P in New Jersey, your enrollment will automatically be transferred into Aetna U.S. Healthcare enrollment Code P3, High Option. However, you may change to a Standard Option enrollment during Open Season. Please review this brochure for your benefits.
- If your are enrolled in Prudential Healthcare HMO Philadelphia enrollment Code VV in Pennsylvania, your enrollment will automatically be transferred into Aetna U.S. Healthcare enrollment Code SU, High Option. However, you may change to a Standard Option enrollment during Open Season. Please review this brochure for your benefits.
- If your are enrolled in Aetna U.S. Healthcare enrollment Code NK in Delaware, your enrollment will automatically be transferred into Aetna U.S. Healthcare enrollment Code SU, High Option. However, you may change to a Standard Option enrollment during Open Season. Please review this brochure for your benefits.
- If your are enrolled in Aetna U.S. Healthcare enrollment Code Z1 in Virginia, your enrollment will automatically be transferred into Aetna U.S. Healthcare enrollment Code XE, High Option. However, you may change to a Standard Option enrollment during Open Season. Please review this brochure for your benefits.
- The Plan expanded its Virginia service area and added a new enrollment code, Code XE. The following counties have been added: Charles, Chesterfield, Colonial Heights, Dinwiddie, Hanover, Henrico, Hopewell, King William, New Kent, Nottaway, Petersburg, Powhattan, and Richmond.
- The Plan expanded its service area for Code SU to add the State of Delaware (formerly Code NK).
- The copay for specialist office under High Option has increased from $10 to $15 per visit. See Sections 5A-5F.

- The copay for specialist office visit under Standard Option has increased from $15 to $20 per visit. See Sections 5A-5F.
- The copay for at home specialist visit under Standard Option has increased from $20 to $25 per visit. See Section 5A.
- The Standard Option per admission copay to treat mental health and substance abuse increased from nothing to $240 to equal the copay for medical and surgical hospital admissions under Standard Option. See page 34.
- Prophylaxis (cleaning of teeth) changed from once every 6 months to cover 2 treatments per year. See page 40.
- Benefits for dental diagnostic and preventive services changed. See page 40.
- For certain age groups, women may now access additional routine mammograms. See page 18.
- Pennsylvania, Code KL. Your share of the Standard Option non-postal premium will increase by 4.1% for Self Only and increase by 3.8% for Self and Family. Your share of the High Option non-postal premium will increase by 0.7% for Self Only and decrease by 8.3% for Self and Family.
- Pennsylvania, Code SU. Your share of the Standard Option non-postal premium will increase by 9.1% for Self Only and increase by 4.2% for Self and Family. Your share of the High Option non-postal premium will decrease by 1.9% for Self Only and decrease by 0.5% for Self and Family.
- New Jersey, Code P3. Your share of the Standard Option non-postal premium will increase by 34.2% for Self Only and increase by 32.3% for Self and Family. Your share of the High Option non-postal premium will decrease by 13.9% for Self Only and decrease by 3% for Self and Family.
- Delaware, Code SU. Your share of the Standard Option non-postal premium will increase by 9.1% for Self Only and increase by 4.2% for Self and Family. Your share of the High Option non-postal premium will decrease by 1.9% for Self Only and increase by 0.5% for Self and Family.
- Maryland, Washington DC and Northern Virginia, Code JN. Your share of the Standard Option non-postal premium will increase by 11.4% for Self Only and increase by 11.1% for Self and Family. Your share of the High Option non-postal premium will decrease by 2.8% for Self Only and decrease by 11.5% for Self and Family.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-537-9384.

Where you get covered care

You get covered care from "Plan providers" and "Plan facilities." You will only pay copayments or coinsurance, and you will not have to file claims.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website at **www.aetnaushc.com/feds**.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these facilities in the provider directory, which we update periodically. The list is also on our website at **www.aetnaushc.com/feds**.

What you must do to get covered care

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

- **Primary care**

Your primary care physician can be a general practitioner, family practitioner, internist or pediatrician. Your primary care physician will provide or coordinate most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us or visit our website. We will change your primary care physician to a newly-selected primary care physician.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see any Plan gynecologist for a routine well-woman exam, including a pap smear (if appropriate) and an unlimited number of visits for gynecological problems and follow-up care as described in your benefit plan without a referral. You may also see a Plan mental health provider, Plan vision specialist or a Plan dentist without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:

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

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-537-9384. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the hospital benefit of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process precertification. Your Plan physician must obtain approval for certain services such as hospitalization or outpatient surgery and the following services:

- For artificial insemination you must contact the Infertility Case Manager at 1-800-575-5999;
- For surgical treatment of morbid obesity;
- For ambulance transportation service;
- For covered transplant surgery from the Plan's medical director;
- When full-time skilled nursing care is necessary in an extended care facility;
- You must obtain precertification from your primary care doctor and Aetna U. S. Healthcare for covered follow-up care with a nonparticipating provider;
- You must contact Customer Service at 1-800-537-9384 for information on precertification before you have mental health and substance abuse services; and
- For certain drugs before they can be prescribed.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

  A copayment is a fixed amount of money you pay to the provider when you receive services.

  Example: Under the High Option, when you see your primary care physician you pay a copayment of $10 per office visit or $15 per office visit when you see a Plan specialist. Under the Standard Option, you pay $15 for a primary care physician office visit, $20 per office visit for a Plan specialist and a $50 copay per outpatient surgical visit. When you go in the hospital, you pay a $240 copay per admission under the Standard Option, you pay nothing under the High Option.

- **Coinsurance**

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

  Example: In our Plan, you pay 50% of charges for drugs to treat sexual dysfunction.

Your out-of-pocket maximum

After your copayments and coinsurance total $1,500 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Prescription drugs
- Dental services

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

Section 5. Benefits — OVERVIEW

(See page 10 for how our benefits changed this year and page 65 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also, read the General Exclusions in Section 6; they apply to the benefits in the following subsections. For more information about our benefits, contact us at 1-800-537-9384 or at our website at **www.aetnaushc.com/feds**.

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay	
Diagnostic and treatment services	**Standard Option**	**High Option**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion • Initial examination of a newborn child covered under a family enrollment	$15 per primary care physician visit $20 per specialist visit	$10 per primary care physician visit $15 per specialist visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
At home	$20 per PCP visit $25 per specialist visit	$15 per PCP visit $20 per specialist visit
At home visits by nurses and health aides	Nothing	Nothing
Lab, X-ray and other diagnostic tests		
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $15 per PCP visit $20 per specialist visit	Nothing if you receive these services during your office visit; otherwise, $10 per PCP visit $15 per specialist visit

Preventive care, adult	**You Pay Standard Option**	**You Pay High Option**
Routine screenings, such as: • Blood lead level — One annually • Total Blood Cholesterol — once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test •• Sigmoidoscopy, screening — every five years starting at age 50	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
Prostate Specific Antigen (PSA test) — one annually for men age 40 and older	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
Routine pap test **NOTE**: Nothing for the pap test if performed on the same day as the office visit.	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
Routine mammogram — covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
• Routine immunizations and boosters	Nothing if provided during the office visit.	Nothing if provided during the office visit.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations and boosters for travel or work-related exposure*	*All charges*	*All charges*

Preventive care, children	You Pay Standard Option	You Pay High Option
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing if provided during the office visit.	Nothing if provided during the office visit.
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction. •• Ear exams through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 22) • Well-child visits for routine examinations, immunizations and care (through age 22)	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
Maternity care		
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care **NOTE**: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended inpatient stay if your Physician determines it is medically necessary. • 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$15 for the first PCP office visit only or $20 for the first specialist visit only	$10 for the first PCP office visit only or $15 for the first specialist visit only
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*	*All charges*

Family planning	You Pay Standard Option	You Pay High Option
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$20 per specialist visit	$15 per specialist visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges*	*All charges*
Infertility services		
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• intravaginal insemination (IVI) •• intracervical insemination (ICI) •• intrauterine insemination (IUI) **NOTE**: Coverage is for 6 cycles. Artificial insemination must be authorized. You must contact the Infertility Case Manager at 1-800-575-5999. You must use our select network of Plan infertility providers. • Fertility drugs **NOTE**: We cover oral fertility drugs under the prescription drug benefit. Injectable fertility drugs are not covered.	$20 per specialist visit	$15 per specialist visit
Not covered: • *Reversal of voluntary, surgically-induced sterility.* • *Treatment for infertility when the cause of the infertility was a previous sterilization.* • *Infertility treatment when the FSH level is greater than 19 mIU/ml.* • *The purchase, freezing and storage of donor sperm and donor embryos.* • *Assisted reproductive technology (ART) procedures not shown, such as in vitro fertilization and embryo transfer including, but not limited to, GIFT and ZIFT.*	*All charges*	*All charges*
Allergy care		
Testing and treatment Allergy injection	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
Allergy serum	Nothing	Nothing

Treatment therapies	You Pay Standard Option	You Pay High Option
• Chemotherapy and radiation therapy **NOTE**: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis — Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy — Home IV and antibiotic therapy • Growth hormone therapy (GHT)	$20 per specialist visit	$15 per specialist visit
Rehabilitative therapies		
Physical therapy, occupational therapy, speech therapy and pulmonary therapy — • Two consecutive months per condition, beginning with the first day of treatment for each of the following: •• Qualified physical therapies •• Speech therapies •• Occupational therapy •• Pulmonary rehabilitation **NOTE**: We only cover speech therapy for certain speech impairments of organic origin. 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. • 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. • Physical therapy to treat temporomandibular joint (TMJ) dysfunction syndrome	$20 per specialist visit	$15 per specialist visit
Not covered: • *Long-term rehabilitative therapy*	*All charges*	*All charges*

Hearing services (testing, treatment, and supplies)	You Pay Standard Option	You Pay High Option
• Hearing testing for children through age 17 (see *Preventive care, children*)	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)		
• Treatment of eye diseases and injury • Routine eye refraction based on the following schedule: •• If member wears eyeglasses or contact lenses: Age 1 through 18 — once every 12-month period Age 19 and over — once every 24-month period •• If member does not wear eyeglasses or contact lenses: To age 45 — once every 36-month period • Age 45 and over — once every 24-month period refractions	$20 per specialist visit	$15 per specialist visit
• Corrective eyeglasses and frames or contact lenses (hard or soft)	All charges over $100 in a 24-month period	All charges over $100 in a 24-month period
Not covered: • *Fitting of contact lenses* • *Eye exercises* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotics*	*All charges*	*All charges*

Orthopedic and prosthetic devices	You Pay Standard Option	You Pay High Option
• External prosthetic devices which replace all or part of an internal or external body organ or an external part. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy, orthopedic devices such as braces and prosthetic devices such as artificial limbs. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, defibrillators, surgically implanted breast implants following mastectomy, and lenses following cataract removal. **NOTE**: Coverage includes repair and replacement when due to growth or normal wear and tear. See 5(b) for coverage of the surgery to insert the device.	Nothing	Nothing
Durable medical equipment (DME)		
Rental or purchase, including replacement, repair and adjustment, of durable medical equipment prescribed by your Plan Physician, such as hospital beds and wheelchairs. Coverage is determined in accordance with Medicare guidelines	Nothing	Nothing
Home health services		
• Home health care ordered by a Plan Physician and provided by nurses and home health aides. Your Plan Physician will periodically review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications.	Nothing	Nothing
Not covered: • *Homemaker services, respite care, services that may be provided in a less costly setting such as a skilled nursing facility*	*All charges*	*All charges*
Alternative treatments		
Chiropractic services up to 20 visits per calendar year	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
Not covered: Any services not listed above	*All charges*	*All charges*

Educational classes and programs	You Pay Standard Option	You Pay High Option
Our L'il Appleseed® Program provides risk screening and assistance for all pregnant members. We also offer special benefits, such as educational literature about pregnancy and childbirth, $40 reimbursement for attending prenatal classes, nurse visits, and discounts on baby products. Also see the Non-FEHB page for our Member Health Education, Informed Health Line and Intelihealth.	Nothing	Nothing

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay	
Surgical procedures	**Standard Option**	**High Option**
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. This procedure must be approved in advance by HMO. • Insertion of internal prosthetic devices. See 5(a) — Orthopedic braces and prosthetic devices for device coverage information. • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) **NOTE**: Devices are covered under 5(a). • Treatment of burns	$20 per specialist visit	$15 per specialist visit
Not covered: • *Reversal of voluntary surgically-induced sterilization* • *Surgery primarily for cosmetic purposes* • *Refractive eye surgery, such as radial keratotomy* • *Blood and blood derivatives, except blood derived clotting factors, and the storage of the patient's own blood for later administration*	*All charges*	*All charges*

Reconstructive surgery	You Pay Standard Option	You Pay High Option
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) **NOTE**: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$20 per specialist visit	$15 per specialist visit
Not covered: • *Cosmetic surgery — any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery		
Oral surgical procedures, such as: • Treatment of fractures of the jaws or facial bones; • Surgical correction of congenital defects, such as cleft lip and cleft palate; • Removal of stones from salivary ducts; • Exclusion of leukoplakia or malignancies; • Removal of bony impacted wisdom teeth; • Excision of tumors and cysts • Other surgical procedures that do not involve the teeth or their supporting structures.	$20 per specialist visit	$15 per specialist visit
Not covered: • *Dental implants* • *Dental care involved with the treatment of temporomandibular joint dysfunction*	*All charges*	*All charges*

Organ/tissue transplants	You Pay Standard Option	You Pay High Option
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: Single — Double • Pancreas • Skin • Tissue • Allogeneic donor bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • National Transplant Program (NTP) — Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplants must be ordered by your Primary Care Physician and specialist physician and approved by our medical director in advance of the surgery. The transplant must be performed at hospitals specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have deter-mined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor to the extent these services are not covered by another plan or program. **NOTE**: We cover related medical and hospital expenses of the donor when we cover the recipient.	$20 per specialist office visit and nothing for the surgery	$15 per specialist office visit and nothing for the surgery
Not covered: • *Transplants not listed as covered*	*All charges*	*All charges*
Anesthesia		
Professional services provided in — • Hospital (inpatient)	Nothing	Nothing
• Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$20 per specialist visit	$15 per specialist visit

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

IMPORTANT

Here are some important things to remember about these benefits:

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

IMPORTANT

Benefit Description	You pay	
Inpatient hospital	**Standard Option**	**High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. **NOTE**: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$240 per admission	Nothing
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 • The withdrawal, processing and storage of the patient's own blood for later administration, and the administration of this blood to the patient • Serum, clotting factors and immunoglobulins • Blood or blood plasma, if not donated or replaced • 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	Nothing	Nothing

Inpatient hospital — *Continued on the next page*

Inpatient hospital *(Continued)*	**You Pay Standard Option**	**You Pay High Option**
Not covered: • *Custodial care, rest cures, domiciliary or convalescent cares* • *Personal comfort items, such as telephone and, television*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center		
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service **NOTE**: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$50 outpatient surgery copay	Nothing
Not covered: Blood and blood derivatives, except blood clotting factors and the patient's own blood for later administration	*All charges*	*All charges*
Extended care benefits/skilled nursing care facility benefits		
Extended care benefit: All necessary services during confinement in an skilled nursing facility with no dollar or day limit when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	Nothing	Nothing
Not covered: custodial care	*All charges*	*All charges*
Hospice care		
Supportive and palliative care for a terminally ill member in the home or hospice facility, including inpatient and outpatient care and family counseling, when provided under the direction of a Plan doctor, who certifies the patient is in the terminal stages of illness, with a life expectancy of approximately 6 months or less.	Nothing	Nothing

Ambulance	You Pay Standard Option	You Pay High Option
• Ambulance service ordered or authorized by a Plan doctor. See Section 5(d) Emergency Care for more details.	Nothing	Nothing
Not covered: Ambulance services for routine transportation to receive outpatient or inpatient services.	*All charges*	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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.

IMPORTANT

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.

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

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

What to Do Outside Your Aetna U.S. Healthcare HMO Service Area

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

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

Follow-up Care after Emergencies

All follow-up care should be coordinated by your PCP. Follow-up care with nonparticipating providers is only covered with a referral from your primary care physician and pre-approval from Aetna U.S. Healthcare. Whether you were treated inside or outside your Aetna U.S. Healthcare service area, you must obtain a referral before any follow-up care can be covered. Suture removal, cast removal, X-rays and clinic and emergency room revisits are some examples of follow-up care.

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, call you primary care doctor. In extreme emergencies or if you are unable to contact your doctor, contact the local emergency system (e.g. the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify your primary care doctor. You or a family member must notify your primary care doctor as soon as possible after receiving emergency care. It is your responsibility to ensure that your primary care doctor has been timely notified.

If you need to be hospitalized, the Plan must be notified as soon as possible. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-participating providers must be approved by us or provided by plan providers.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified as soon as possible. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-participating providers must be approved by us or provided by plan providers.

Benefit Description	You pay	
Emergency within our service area	**Standard Option**	**High Option**
• Emergency care at a doctor's office	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
• Emergency care as an outpatient in a hospital or an urgent care center **NOTE**: If the emergency results in admission to a hospital, the copay is waived.	$35 per visit	$35 per visit
Not covered: Elective care or non-emergency care	*All charges*	*All charges*

Emergency outside our service area	Standard Option	High Option
• Emergency care at a doctor's office	$15 per PCP visit $20 per specialist visit	$10 per PCP visit $15 per specialist visit
• Emergency care as an outpatient in a hospital or an urgent care center **NOTE**: If the emergency results in admission to a hospital, the copay is waived.	$35 per visit	$35 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area exclusion*	*All charges*	*All charges*
Ambulance		
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing	Nothing
Not covered: air ambulance	*All charges*	*All charges*

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

Network Benefit		
IMPORTANT	**Parity** Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past. When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for participating mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions. **Here are some important things to keep in mind about these benefits:** • All benefits are subject to the definitions, limitations, and exclusions in this brochure. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.	IMPORTANT

Description	You pay	
Mental health and substance abuse benefits	**Standard Option**	**High Option**
Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. **NOTE**: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.	Same as Standard Option
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$20 per visit	$15 per visit
• Diagnostic tests	$20 per visit	$15 per visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment.	$240 per admission	Nothing

Mental health and substance abuse benefits — *Continued on the next page*

Mental health and substance abuse benefits *(Continued)*	You Pay Standard Option	You Pay High Option
Not covered: • *Services we have not approved.* • *Out of Network mental health and substance abuse services.* **NOTE**: *OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*All charges*

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

Contact Customer Services at 1-800-537-9384 to identify providers and obtain information on the referral process.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a participating mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Network limitation

We may limit your benefits if you do not follow your treatment plan.

How to submit network claims

Mail your itemized bills to Aetna U.S. Healthcare, P.O. Box 1125, Blue Bell, PA 19422.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are a medically necessary.
- 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.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician or dentist must write the prescription.
- **Where you can obtain them.** You must fill non-emergency prescriptions at a Plan pharmacy for up to a 30-day supply, or by mail for a 31-90 day supply of medication (if authorized by your physician). Please call Member Services at 1-800-537-9384 for more details on how to use the mail order program. In an emergency or urgent care situation, you may fill your covered prescription at any retail pharmacy. If you obtain your prescription at a pharmacy that does not participate with the plan, you will need to pay the pharmacy the full price of the prescription and submit a claim for reimbursement subject to the terms and conditions of the plan.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The Plan's formulary does not exclude medications from coverage, but requires a higher copayment for nonformulary drugs. Nonformulary drugs will be covered when prescribed by a Plan doctor. Certain drugs require your doctor to get precertification from the Plan before they can be prescribed under the Plan. Visit our website at **www.aetnaushc.com/feds** to review our Formulary Guide or call 1-800-537-9384.
- **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.

  The precertification program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information.

  The drugs requiring precertification are subject to change. Visit our website for the current Precertification List.
- **These are the dispensing limitations.** Covered prescription drugs prescribed by a licensed physician or dentist and obtained at a Participating Plan Pharmacy may be dispensed for up to a 30-day supply. Members must obtain a 31- to 90-day supply of covered prescription of covered prescription medication through mail order.
- **When you have to file a claim.** Send your itemized bill(s) to: Aetna U.S. Healthcare, P.O. Box 1125, Blue Bell, PA 19422.

Prescription drug benefits — *Begin on the next page.*

Benefit Description	You pay	
Covered medications and supplies	**Standard Option**	**High Option**
We cover the following medications and supplies prescribed by the physician or dentist and obtained from a Plan or through our mail order program: • Drugs for which a prescription is required by Federal law. • Oral contraceptive drugs. • Insulin • Disposable needles and syringes needed to inject covered prescribed medication, including insulin. • Diabetic supplies limited to lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips • Oral fertility drugs • Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galectosemia, and homocystinuria when administered under the direction of a Plan doctor. • Intravenous fluids and medications for home use, implantable drugs, such as Norplant, IUDs, and some injectable drugs are covered. See Section 5A for details.	$10 per covered generic formulary prescription/refill (up to a 30 day supply) or $20 for a 31- to 90-day supply through mail order $15 per covered brand name formulary prescription/refill (up to a 30 day supply) or $30 for a 31- to 90-day supply through mail order $30 per covered non-formulary (generic or brand) prescription/refill (up to a 30 day supply) or $60 for a 31- to 90-day supply through mail order	$5 per covered generic formulary prescription/refill (up to a 30 day supply) or $10 for a 31- to 90-day supply through mail order $10 per covered brand name formulary prescription/refill (up to a 30 day supply) or $20 for a 31- to 90-day supply through mail order $25 per covered non-formulary (generic or brand) prescription/refill (up to a 30 day supply) or $50 for a 31- to 90-day supply through mail order
Limited benefits • Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. • Depo Provera is limited to 5 vials per calendar year. • One diaphragm per calendar year	50% $15 copay per vial $15 per diaphragm	50% $10 copay per vial $10 per diaphragm

Covered medications and supplies — *Continued on the next page*

Covered medications and supplies *(Continued)*	**You Pay Standard Option**	**You Pay High Option**
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. • To request a copy of the Aetna U.S. Healthcare Medication Formulary Guide, call 1-800-537-9384 or visit out website at **www.aetnaushc.com/feds**.		
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available, (i.e., an over- the-counter (OTC) drug)* • *Drugs obtained at a non-Plan pharmacy, except when related to out-of-area emergency care* • *Vitamins and nutritional substances that can be purchased without prescription.* • *Medical supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance.* • *Smoking-cessation drugs and medication, including, but not limited to, nicotine patches and sprays.* • *Injectable fertility drugs* • *Drugs used for the purpose of weight reduction (i.e., appetite suppressants).*	*All charges*	*All charges*

Section 5 (g). Special Features

Feature	Description
Services for the deaf and hearing-impaired	1-800-628-3323
Reciprocity benefit	If you need to visit a participating primary care physician for a covered service, and you are 50 mile or more away from home you may visit a primary care physician from our Plan's approved network. • Call 1-800-537-9384 for provider information and location • Select a doctor from 3 primary care doctors in that area • The Plan will authorize you for one visit and any tests or X-rays ordered by that primary care physician. • You must coordinate all subsequent visits through your own participating care physician.
High risk pregnancies	Our L'il Appleseed® Program provides risk screening and assistance for all pregnant members. We also offer special benefits, such as educational literature about pregnancy and childbirth, $40 reimbursement for attending prenatal classes, nurse visits, and discounts on baby products.
Centers of excellence for transplants/heart surgery/etc	Our National Medical Excellence Program® coordinates services for complicated or rare illnesses and transplants. The National Medical Excellence Program is unique to Aetna U.S. Healthcare and has been created for members with particularly difficult conditions such as rare cancers and other complicated diseases and disorders. Usually, the recommended treatment can be found in your area. But if your needs extend beyond your region, the National Medical Excellence Program may be available to send you to out-of-area experts. The first priority is to determine an appropriate treatment program. If your treatment program cannot be provided in the local area, we will arrange and pay for covered care as well as related travel expenses to wherever the necessary care is available. Prior approval is required.
Travel benefit/ services overseas	Our National Medical Excellence Program is a case management program that provides consistency in the coordination of care for life threatening and complex illnesses. This includes bone marrow and solid organ transplants, investigational and new technology (when covered), and unique services that are offered at a limited number of medical facilities. We also coordinate care for members if they need covered care that is not available in their local area and if they become ill when traveling temporarily outside the Continental United States.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange covered care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- 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.

IMPORTANT

Accidental injury benefit

No benefits other than those listed on the following schedule.

Dental Benefits		
Service	**Standard Option You Pay**	**High Option You Pay**
Diagnostic		
Office visit for oral evaluation — limited to 2 visits per year	$5	$5
Bitewing x-rays — limited to 2 sets of bitewing x-rays per year	$5	$5
Entire x-ray series — limited to 1 entire x-ray series in any 3 year period	$5	$5
Periapical x-rays and other dental x-rays — as necessary	$5	$5
Diagnostic models	$5	$5
Preventive		
Prophylaxis (cleaning of teeth) — limited to 2 treatments per year	$5	$5
Topical fluoride — limited to 2 courses of treatment per year and to children under age 18	$5	$5
Oral hygiene instruction	$5	$5
Restorative (Fillings)		
Amalgam (primary) 1 surface	$5	$5
Amalgam (primary) 2 surfaces	$5	$5
Amalgam (primary) 3 surfaces	$5	$5
Amalgam (primary) 4 surfaces	$5	$5
Amalgam (permanent) 1 surface	$5	$5
Amalgam (permanent) 2 surfaces	$5	$5
Amalgam (permanent) 3 surfaces	$5	$5
Amalgam (permanent) 4 surfaces	$5	$5

Dental benefits — *Continued on next page*

Dental Benefits *(Continued)*		
Service	**Standard Option You Pay**	**High Option You Pay**
Prosthodontics Removable		
Denture adjustments (complete or partial/upper or lower)	$5	$5
Endodontics		
Pulp cap — direct	$5	$5
Pulp cap — indirect	$5	$5
NOTE: The above services are only covered when provided by your participating primary care dentist in accordance with the terms of your Plan. *If rendered by a participating specialist, they are provided at reduced fees. Pediatric dentists are considered specialists.* Certain other services will be provided by your primary care dentist at reduced fees. A partial list appears below. Ask your primary care dentist for a complete schedule of current reduced member fees. All member fees must be paid directly to the participating dentist. Each employee and dependent must select a primary care dentist from the directory and include the dentist's name on the enrollment or provider selection form. The following procedures are also available from your participating primary care dentist up to the maximum fee shown. *These same services received from a participating specialist may require you to pay a fee that is higher than the stated maximum*. Call your participating primary care dentist or participating dental specialist for the specific fee in your area.		

Dental Benefits *(Continued)*		
Service	**Standard Option You Pay up to a maximum fee of**	**High Option You Pay up to a maximum fee of**
Diagnostic		
Sealant — per permanent tooth	$ 35	$ 35
Space maintainer	$445	$445
Restorative (Fillings)		
Resin (anterior) 1 surface	$ 85	$ 85
Resin (anterior) 2 surfaces	$115	$115
Resin (anterior) 3 surfaces	$140	$140
Resin (anterior) 4 or more surfaces or incisal angle	$150	$150
Metallic inlay	$580	$580
Prosthodontics, removable		
Complete denture, (upper or lower)	$820	$820
Immediate denture (upper or lower)	$885	$885
Partial denture resin base (upper or lower)	$630	$630
Partial denture cast metal framework with resin base (upper or lower)	$955	$955
Denture repairs	$120	$120
Add tooth to existing partial	$105	$105
Add clasp to existing partial	$120	$120
Denture rebase	$300	$300
Denture relines	$260	$260
Interim denture (complete or partial/upper or lower)	$370	$370
Tissue conditioning	$ 85	$ 85
Prosthodontics, fixed		
Bridge pontic	$685	$685
Metallic inlay/onlay	$650	$650
Cast metal retainer for resin bonded prosthesis	$250	$250
Crown porcelain	$685	$685
Crown cast	$690	$690
Recement bridge	$ 65	$ 65
Post and core	$250	$250
Oral surgery		
Extractions (nonsurgical and tissue impacted)	$380	$380
Anesthesia (general in office, first half-hour session)	$215	$215

Dental benefits — *Continued on next page*

Dental Benefits *(Continued)*		
Service	**Standard Option You Pay up to a maximum fee of**	**High Option You Pay up to a maximum fee of**
Periodontics (Gum treatment)		
Gingivectomy per quadrant	$250	$250
Gingival curretage per quadrant	$120	$120
Periodontal surgery	$605	$605
Provisional splinting	$125	$125
Scaling and root planing per quadrant	$120	$120
Periodontal maintenance procedure	$ 85	$ 85
Endodontics (Root canal)		
Therapeutic pulpotomy	$100	$100
Root canals (anterior, bicuspid, molar) excluding final restoration	$605	$605
Apicoectomy — anterior	$405	$405
Orthodontics		
Pre-orthodontic treatment visit	$280	$280
Fully banded case (adult age 19 and over)	$4,400	$4,400
Fully banded case (child age 18 and under)	$4,400	$4,400
Specific fees vary by area of the country up to the stated maximum. Ask your primary care dentist for a complete schedule of reduced fees.		
Services not received from a participating dental provider are not covered. We offer no other dental benefits than those shown above.	*All charges*	*All charges*

Section 5 (i). Non-FEHB benefits available to Plan members

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

Member Health Education

With our programs, Aetna U.S. Healthcare offers special health education, preventive care and wellness programs. We provide our members with materials that promote a healthy lifestyle and good health.

The **Healthy Eating™ Program** is an easy-to-follow approach to better health through good nutrition. It's designed to provide members and their families with information to develop a long-term healthy eating plan that is also realistic. Members will also understand how to reduce their risk of illness and disease, manage their weight, increase their energy level and boost their ability to fight illness.

Our Healthy Breathing® Smoking-Cessation Program will help you safely quit smoking with educational materials, phone support and discounts on over-the-counter smoking-cessation products. The member may also enroll in an eight-to-twelve week smoking-cessation program.

Intelihealth®

We offer InteliHealth, our affiliate website (**www.intelihealth.com**) that provides timely, relevant, reliable and easy-to-understand health information online. Established in 1996, InteliHealth has received international acclaim for the second straight year by being named the "People's Choice" in the Webby Awards health category. The Webby awards are presented annually by the International Academy of Digital Arts and Sciences.

Vision One®[1]

You are eligible to receive significant discounts on eyeglasses, contact lenses and nonprescription items including sunglasses and eyewear products through the **Vision One Program** (1-800-793-8616) at more than 4,000 locations across the country.

The discount enriches our routine vision care coverage provided in your health plan, which includes an eye exam from a participating provider. If your health plan also includes coverage for eyewear such as prescription eyeglasses or contact lenses, your out-of-pocket expenses can be reduced when you use your Vision One discount.

Informed Health® Line

Provides eligible members with telephone access to registered nurses experienced in providing information on a variety of health topics. Informed Health Line is available 24 hours a day, 7 days a week. You may call Informed Health Line at 1-800-556-1555, Informed health Line nurses cannot diagnose, prescribe medication or give medical advice.

Medicare Managed Care Plan Enrollment

This Plan offers Medicare recipients (those enrolled only in codes P3, SU and parts of KL) the opportunity to enroll in the Plan through Medicare. As indicated on page 51, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare managed care plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare managed care plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare managed care plan. Contact us at 1-800-282-5366 for information on the Medicare managed care plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-282-5366 for information on the benefits available under the Medicare HMO.

[1] Vision One is a registered trademark of Cole Vision.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 14.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (See Emergency Benefits);
- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this plan.

Section 7. Filing a claim for covered services

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

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

Medical, Hospital and Drug benefits

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

When you must file a claim — such as for out-of-area care — submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: Aetna U.S. Healthcare, Inc., 1425 Union Meeting Road, P.O. Box 1125, Blue Bell, PA 19422

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Aetna U.S. Healthcare, Inc., 1425 Union Meeting Road, P.O. Box 1125, Blue Bell, PA 19422; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial — go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. **NOTE**: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

NOTE: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

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

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

6 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. This is the only deadline that may not be extended.

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

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

NOTE: If you have a serious or life threatening condition **(one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and**

a) If we haven't responded yet to you 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 can call OPM's health Benefits Contracts Division III at 202-606-0737 between 8 a.m. and 5 p.m. eastern time.

External Review

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

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

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

To request an External Review Form call 1-800-537-9384 within 60 days after receiving the Plan's written notification that it will uphold its original decision to deny your claim.

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

To request a detailed description of the external review requirements, call the Plan's Member Relations Office at 1-800-537-9384.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

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

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

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

• The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your must continue to be authorized by your PCP, or precertified as required.

We will not waive any of our copayments and coinsurance.

(Primary payer chart begins on next page.)

The following chart illustrates whether Original 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 either you — or your covered spouse — are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when …		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) 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,	✓ (except for claims related to Workers' Compensation.)	
B. When you — or a covered family member — have Medicare based on end stage renal disease (ESRD) and …		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and …		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee		✓

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

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB coverage.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care Plan's network and/or service area (if you use our Plan Providers), but we will not waive any of our copayments or coinsurance.

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

- **Enrollment in Medicare Part B**

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for members, eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

You and your representatives further agree to:

- Notify us promptly and in writing when notice is given to any third party of the intention to investigate or pursue a claim to recover damages or obtain compensation due to injuries or illness sustained by us that may be the legal responsibility of a third party; and
- Cooperate with us and do whatever is necessary to secure our rights of subrogation and/or reimbursement under this Plan; and
- Give us a first-priority lien on any recovery, settlement or judgment or other source of compensation which may be had from a third party to the extent of the full cost of all benefits associated with injuries or illness provided by us for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment or compensation agreement); and

- Pay, as the first priority, from any recovery, settlement or judgment or other source of compensation, any and all amounts due us as reimbursement for the full cost of all benefits associated with injuries or illness provided by us for which a third party is or may be responsible (regardless of whether specifically set forth in the recovery, settlement, judgment, or compensation agreement), unless otherwise agreed to by us in writing; and

- Do nothing to prejudice our rights as set forth above. This includes, but is not limited to, refraining from making any settlement or recovery which specifically attempts to reduce or exclude the full cost of all benefits provided by us.

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

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

Coinsurance

Coinsurance is the percentage of expenses that you must pay for your care. See page 15.

Covered services

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

Custodial care

Any type of care provided in accordance with 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, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to your daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this includes, but is not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the you, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of us, 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, convalescent care

Detoxification

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

Experimental or investigational services

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

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

Medical necessity

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

Reasonable Charge

The charge for a Covered Benefit which is determined by us to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. We may take into account factors such as the complexity, degree of skill needed, type or specialty of the Provider, range of services provided by a facility, and the prevailing charge in other areas in determining the Reasonable Charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

Referral

Specific directions or instructions from your PCP, in conformance with our policies and procedures, that direct you to a participating provider for medically necessary care.

Respite Care

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

Urgent Care

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

Us/We

Us and we refer to Aetna U.S. Healthcare, Inc.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form, benefits will not be available to your spouse until you marry.

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

  You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

- **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.

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

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

- **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

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.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

- **Penalties for Fraud**

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for a person who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2000 open season, November 13, 2000, through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 open seasons. Your coverage will begin January 1 of the year following the open season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at **www.tricare.osd.mil/fehbp**. You can also view information about the demonstration project, including "The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at **www.opm.gov**.

TCC eligibility

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

NOTES:

Summary of benefits for Aetna U.S. Healthcare® — 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by participating physicians, except in emergencies.

Benefits	You Pay- High Option	You Pay- Standard Option	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $15 specialist	Office visit copay: $15 primary care; $20 specialist	17
Services provided by a hospital: • Inpatient • Outpatient	 Nothing Nothing	 $240 per admission copay $50 copay per outpatient surgical visit	 28 29
Emergency benefits: • In-area • Out-of-area	 $35 per visit $35 per visit	 $35 per visit $35 per visit	 32 33
Mental health and substance abuse treatment	Same as medical and hospital benefits	Same as medical and hospital benefits	34
Prescription drugs	30 day supply: $5 per generic formulary $10 per brand name formulary $25 per non-formulary 2 times copay for 31-90 day supply	30 day supply: $10 per generic formulary $15 per brand name formulary $30 per non-formulary 2 times copay for 31-90 day supply	36
Dental Care	Variable copays	Variable copays	40
Vision Care	$15 copay per visit. Up to $100 reimbursement for eyeglasses or contacts per 24 month period	$20 copay per visit. Up to $100 reimbursement for eyeglasses or contacts per 24 month period	22
Special features: Services for the deaf and hearing-impaired, and Center of Excellence for transplants/heart surgery/etc.	Contact Plan	Contact Plan	39

Benefits	You Pay- High Option	You Pay- Standard Option	Page
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $3,000/Family enrollment per year in copayments. Copayments towards prescription drugs, behavioral health and dental services do not count towards these limits.	Nothing after $1,500/Self Only or $3,000/Family enrollment per year in copayments Copayments towards prescription drugs, behavioral health and dental services do not count towards these limits	15

2001 Rate Information for Aetna U.S. Healthcare

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Southeastern Pennsylvania and Delaware							
High Option Self Only	SU1	$86.59	$36.29	$187.61	$78.63	$102.22	$20.66
High Option Self and Family	SU2	$195.82	$119.29	$424.28	$258.46	$231.17	$83.94
Standard Option Self Only	SU4	$80.99	$27.00	$175.49	$58.49	$95.84	$12.15
Standard Option Self and Family	SU5	$195.82	$82.95	$424.28	$179.72	$231.17	$47.60
Southwestern, Central and Northeastern Pennsylvania							
High Option Self Only	KL1	$68.67	$22.89	$148.79	$49.59	$81.26	$10.30
High Option Self and Family	KL2	$181.72	$60.57	$393.72	$131.24	$215.03	$27.26
Standard Option Self Only	KL4	$59.63	$19.88	$129.20	$43.07	$70.57	$8.94
Standard Option Self and Family	KL5	$158.65	$52.88	$343.74	$114.58	$187.73	$23.80

2001 Rate Information for Aetna U.S. Healthcare *continued*

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
New Jersey							
High Option Self Only	P31	$86.59	$49.89	$187.61	$108.10	$102.22	$34.26
High Option Self and Family	P32	$195.82	$156.20	$424.28	$338.43	$231.17	$120.85
Standard Option Self Only	P34	$86.59	$34.17	$187.61	$74.04	$102.22	$18.54
Standard Option Self and Family	P35	$195.82	$121.86	$424.28	$264.03	$231.17	$86.51
Washington, DC, North and Central Maryland and Northern Virginia							
High Option Self Only	JN1	$85.69	$28.56	$185.66	$61.88	$101.40	$12.85
High Option Self and Family	JN2	$195.82	$68.43	$424.28	$148.26	$231.17	$33.08
Standard Option Self Only	JN4	$62.37	$20.79	$135.14	$45.04	$73.80	$9.36
Standard Option Self and Family	JN5	$145.95	$48.65	$316.22	$105.41	$172.71	$21.89
Central, Richmond and Tri-Cities Virginia							
High Option Self Only	XE1	$73.29	$24.43	$158.80	$52.93	$86.73	$10.99
High Option Self and Family	XE2	$190.15	$63.38	$411.99	$137.33	$225.01	$28.52
Standard Option Self Only	XE4	$65.21	$21.74	$141.29	$47.10	$77.17	$9.78
Standard Option Self and Family	XE5	$169.45	$56.48	$367.14	$122.38	$200.51	$25.42