Aetna U.S. Healthcare® 2002

http://www.aetnaushc.com/feds

A Health Maintenance Organization

Serving the following states:

Arizona
California
Georgia
Nevada
New Jersey
Pennsylvania
Washington

For changes in benefits see page 11.

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 9 for requirements.

Arizona
2/99
This service has Commendable accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

California
5/00
This service has Commendable accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

Georgia
10/00
This service has Excellent accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

New Jersey
3/01
This service has Excellent accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

Pennsylvania
12/99
This service has Excellent accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

Special Notice 1
Members in Pennsylvania, New Jersey and Delaware:

- If you live in **Pennsylvania**, **New Jersey** and **Delaware** your Aetna plan now has only one option. If you were a Standard Option enrollee, you will be automatically transferred to High Option, unless you make an Open Season change. We will send you brochure RI 73-778 before Open Season. Please review it for your benefit changes.
- Your enrollment in code SU will automatically merge into enrollment code P3.
- If you live in **Delaware**, we removed Delaware from our service area. You must travel to our service area in New Jersey or certain Pennsylvania counties in order to receive full HMO benefits.

Special Notice 2
Members in Indiana, Kentucky, New York, Ohio and Tennessee:

- Your enrollment was automatically transferred to our new Plan described in Federal brochure RI 73-806. We will send you brochure RI 73-806 before Open Season. Please review it for details about how your 2002 benefits change.

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

Federal Employees
Health Benefits Program

RI 73-778

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 2836) 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, 2002, unless these benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 11. Rates are shown at the end of this brochure.

*HMO benefits are provided or administered by:

Carrier Code	Legal Entity
P3 (PA)	United States Health Care Systems of Pennsylvania, Inc. D/B/A Aetna U.S. Healthcare Inc. (PA)
P3 (NJ)	Aetna U.S. Healthcare Inc.
2X	Aetna U.S. Healthcare of California Inc.
2U	Aetna U.S. Healthcare of Georgia Inc.
WQ/8L	Aetna U.S. Healthcare Inc. (AZ)
8J	Aetna U.S. Healthcare Inc. (WA)

Plain language

Teams of Government and health plan's staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

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

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

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 someone 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.

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 Plan 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.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, or our 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 57.)

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. 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 or an appeal.

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 you 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

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

Arizona

2/99

This service has Commendable accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

Serving: Phoenix and Tucson areas

Enrollment Code:

WQ1 Self Only
WQ2 Self and Family

Cochise, Maricopa, Pima and Santa Cruz counties and portions of Pinal as defined by the towns of Apache Junction and Casa Grande

California

5/00

This service has Commendable accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

Serving: Southern California area

Enrollment Code:

2X1 Self Only
2X2 Self and Family

Los Angeles, Orange, San Diego, Santa Barbara and Ventura counties, and portions of Riverside, Kern and San Bernardino defined by listed towns:

Riverside County: all towns except Blythe, Mesa Verde, Ripley and Desert Center

San Bernardino County: All towns except Nipton, Ivonpah, Needles, Lake Havasu, Parker Dam, Earp, Big River, Cima, Kelso, Baker, Amboy, Cadiz, Vidal, Rice, Essex and Danby

Kern County: All towns except Ridgecrest, China Lake, Mojave, Garlock, Johannesburg and Cantil

Georgia

10/00

This service has Excellent accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

Serving: The Atlanta and Athens areas

Enrollment Code:

2U1 Self Only
2U2 Self and Family

Barrow, Bartow, Butts, Cherokee, Clarke, Clayton, Cobb, Coweta, Dawson, Dekalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Hall, Haralson, Heard, Henry, Jackson, Lamar, Madison, Newton, Oconee, Oglethorpe, Paulding, Pickens, Pike, Rockdale, Spalding and Walton counties

Nevada

Serving: Southern Nevada and Las Vegas area

Enrollment Code:

8L1 Self Only
8L2 Self and Family

Clark county

New Jersey

3/01

This service has Excellent accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

Serving: All of New Jersey

Enrollment Code:

P31 Self Only
P32 Self and Family

The State of New Jersey

Pennsylvania

12/99

This service has Excellent accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

Serving: Southeastern Pennsylvania

Enrollment Code:

P31 Self Only
P32 Self and Family

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

Washington

Serving: Western and Southeast Washington areas

Enrollment Code:

8J1 Self Only
8J2 Self and Family

King, Kitsap, Pierce and Snohomish counties

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

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

Section 2. How we change for 2002

Program-wide changes

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

Changes to this Plan

- Code WQ. Your share of the non-postal premium will increase by 18.7% for Self Only or increase by 18.8% for Self and Family.
- Code 2X. Your share of the non-postal premium will increase by 12.6% for Self Only or increase by 12.7% for Self and Family.
- Code 2U. Your share of the non-postal premium will increase by 16.4% for Self Only or increase by 16.4% for Self and Family.
- Code 8L. Your share of the non-postal premium will increase by 21.5% for Self Only or increase by 20.6% for Self and Family.
- Code P3. Your share of the non-postal premium will decrease by 7.8% for Self Only or decrease by 3.5% for Self and Family.
- Code 8J. Your share of the non-postal premium will increase by 25.0% for Self Only or increase by 25.4% for Self and Family.
- New Jersey, Code P3. With the elimination of the Standard Option, your share of the non-postal bi-weekly premium (to go from the Standard Option to the High Option) will increase by $11.85 for Self Only and by $28.82 for Self and Family. Non-postal monthly premiums will increase by $25.67 for Self Only and increase by $62.44 for Self and Family.
- Pennsylvania, Code P3 (formerly Code SU — High Option). As a result of this plan merging under P3, your share of the non-postal bi-weekly premium will increase by $9.73 for Self Only and by $31.39 for Self and Family. Non-postal monthly premiums will increase by $21.25 for Self Only and increase by $68.01 for Self and Family.
- Pennsylvania, Code P3 (formerly Code SU — Standard Option). With the elimination of the Standard Option and Code SU merging under P3, your share of the non-postal bi-weekly premium for the High Option will increase by $19.02 for Self Only and by $67.73 for Self and Family. Non-postal monthly premiums will increase by $41.22 for Self Only and increase by $146.75 for Self and Family.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover routing screening for chlamydial infection. (Section 5(a))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We changed the address for sending disputed claims to OPM. (Section 8)
- We eliminated a portion of our service and enrollment areas for calendar year 2002. Members who live or work in the following states must select a new Plan under the FEHB Program: **California** (code BU), **Colorado** (code 6F), **Connecticut** (code H1), **Indiana** (XC), **Illinois** (codes XC and D4), **Kansas** (code 7K), **Louisiana** (code NG), **Massachusetts** (code NE), **Michigan** (code 8Z), **Missouri** (codes 7K and D4), **North Carolina** (code 3G), **Ohio** (code 7J), **Oklahoma** (code 8V), **Rhode Island** (code 5U), and **Texas** (codes 5B and 8X). If you do not change to another Plan during Open Season you will not have benefits in 2002.
- We reduced our service and enrollment area for this Plan. Members who live or work in **Indiana** (codes 7L or RD)**, Kentucky** (codes 7L or RD)**, New York** (codes JC or TG)**, Ohio** (codes RD or 7D) and **Tennessee (**code 6J**),** your enrollment was automatically transferred to Aetna's new Plan. Please review brochure RI 73-806 for details about your benefits.

- We expanded our service and enrollment area to include Southeastern **Pennsylvania** and all of **New Jersey.** See page 9 for details**.**
- We moved members who are enrolled in **Pennsylvania** (code SU) and **New Jersey** (code P3) from our Aetna U.S. Healthcare Plan described in brochure, RI73-052, to this Plan. If you do not make an Open Season change for contract year 2002, you will be enrolled in this Plan, under code P3. If you were a Standard Option enrollee, you will be automatically transferred to High Option unless you make an Open Season change.
- Members enrolled in **Delaware** who do not make an Open Season change must receive services in our service area in Southeastern **Pennsylvania** or **New Jersey** except for emergency care.
- If you are enrolled in code WQ in **Arizona** and live or work in the following counties: Graham, Yuma, and Yavapai, you must select another Plan during Open Season. We eliminated these counties from our service and enrollment area. If you do not change plans, you will have to travel to our remaining service area for code WQ to receive full HMO benefits.
- If you are enrolled in code 2X in **California** and live or work in the following counties: San Bernadino, Kerns and Riverside, you must select another Plan during Open Season. We reduced the size of these counties in our service and enrollment area. If you do not change plans, you will have to travel to our remaining service area for code 2X to receive full HMO benefits.
- If you are enrolled in code 2U in **Georgia** and live or work in the following counties: Burke, Columbia, Glascock, Lincoln, McDuffie, Richmond, Taliaferro, Warren and Wilkes, you must select another Plan during Open Season. We eliminated these counties from our service and enrollment area. If you do not change plans, you will have to travel to our remaining service area for code 2U to receive full HMO benefits.
- If you are enrolled in code 8J in **Washington** and live or work in the following counties: Columbia and Walla Walla, you must select another Plan during Open Season. We eliminated these counties from our service and enrollment area. If you do not change plans, you will have to travel to our remaining service area for code 8J to receive full HMO benefits.
- We now cover certain intestinal transplants. See Section 5(b).
- We changed the primary care doctor office visit copay to $15. See Section 5(a).
- We changed the primary care doctor home visit copay to $20. See Section 5(a).
- We changed the increase the specialty care office visit copay to $20. See Section 5(a).
- We changed the specialty care home visit copay to $25. See Section 5(a).
- We removed the age limit for hearing tests. See Section 5(a).
- We removed the copay for professional services of a physician during an in-patient hospital stay. See Section 5(b).
- We added a $75 copay per date of service for outpatient surgery. See Section 5(c).
- We added an inpatient hospital copay of $100 per day up to a maximum $300 per admission. See Section 5(c).
- We reduced the skilled nursing facility visit maximum from unlimited to 90-day maximum. See Section 5(c).
- We increased the copay from $35 to $75 per emergency room visit. See Section 5(d).
- We added coverage for air ambulance. See Section 5(d).
- We added a $20 copay per visit for outpatient mental health and substance abuse services provided by a hospital or other facility, including alternative care settings such as partial hospitalization, full-day hospitalization and facility based outpatient treatment centers. See Section 5(e).
- We added a copay of $100 per day up to a maximum of $300 per admission. This applies to medical confinements, residential treatment facilities and inpatient hospital admissions to treat mental health and substance abuse. See Section 5(e).
- We increased the copay for generic formulary prescription drugs from $5 to $10 for up to a 30- day supply. The copay increased from $10 to $20 per prescription per mail order 31- to 90-day supply of generic formulary prescription drug. See Section 5(f).

- We increased the copay for brand name formulary drugs from $10 to $20 for up to a 30- day supply. The copay increased from $20 to $40 per prescription per mail order 31 to 90-day supply of brand name formulary prescription drug. See Section 5(f).
- We increased the copay for non-formulary generic and brand name drugs from $25 to 50% for up to a 30-day supply. The copay increased from $50 to 50% per prescription per mail order 31 to 90-day supply of non-formulary generic or brand name prescription drug. See Section 5(f).
- We increased the copay to $20 per diaphragm. See Section 5(f).
- We increased the copay for Depo Provera to $20 per vial. See Section 5(f).
- We increased the copay for certain dental services. See Section 5(h).
- We stated your out-of-pocket maximum of $1,500 for self-only and $3,000 for self and family enrollments. See Section 4.
- We clarified the benefit for blood or blood plasma. See Section 5(c).
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. See Section 5(a).
- We stated growth hormone therapy requires prior authorization.

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 most current information on our Plan providers 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 most current information on our Plan facilities 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. If you need laboratory, radiological and physical therapy services, your primary care physician must refer you to certain plan providers. Your primary care physician may refer you to any participating specialist for other specialty care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a Plan gynecologist, (within an IPA, you must see an IPA-approved 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 benefits 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.

You must obtain approval for certain services such as:

- For artificial insemination you must contact the Infertility Case Manager at 1-800-575-5999;
- You must obtain precertification from your primary care doctor and Aetna U.S. Healthcare for covered follow-up care with 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;

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

- For surgical treatment of morbid obesity;
- For outpatient surgery;
- For covered transplant surgery from the Plan's medical director;
- When full-time skilled nursing care is necessary in an extended care facility;
- For ambulance transportation service; and
- For certain drugs before they can be prescribed;
- For growth hormone therapy treatment.

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

Section 4. Your 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, facility, pharmacy, etc. when you receive services.

  Example: When you see your primary care physician you pay a copayment of $15 per office visit or $20 when you see a participating specialist.

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

  Example: In our Plan, you pay 50% of negotiated charges for nonformulary drugs.

- **Deductible** — We do not have a deductible.

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

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 11 for how our benefits changed this year and page 70 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	
Professional services of physicians • In physician's office – Office medical consultations – Second surgical or medical opinion – Initial examination of a newborn child covered under a family enrollment	$15 per primary care physician (PCP) visit $20 per specialist visit
Professional services of physicians • In an urgent care center for a routine service • In a skilled nursing facility	$15 per PCP visit $20 per specialist visit
At home	$20 per PCP visit $25 per specialist visit
At home visits by nurses and health aides	Nothing
Lab, X-ray and other diagnostic tests	
Test, 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 or $20 per specialist visit

Preventive care, adult	You pay
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening — every five years starting at age 50 Prostate Specific Antigen (PSA test) — one annually for men age 40 and older Routine Pap test **NOTE**: No copay for the pap test if performed on the same day as the office 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 Nothing if provided during the office visit
Routine immunizations limited to: • Tetanus-diphtheria (Td) booster — once every 10 years, ages 19 and over (except as provided for under childhood immunizations • Influenza/Pneumococcal vaccines, annually, age 65 and over	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*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child visits for routine examinations, immunizations and care (up to age 22)	$15 per PCP visit $20 per specialist visit
• Examinations, such as: – Eye exams through age 17 to determine the need for vision correction. – Ear exams to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22)	$15 per PCP visit $20 per specialist visit

Maternity care	You pay
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 visit only or $20 for the first specialist visit only
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives, such as Norplant • Injectable contraceptive drugs, such as Depo Provera • Intrauterine devices (IUDs) • Diaphragms **NOTE:** We cover oral contraceptives and Depo Provera under the prescription drug benefit.	$15 per PCP visit $20 per specialist visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*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 except injectables **NOTE**: We cover oral fertility drugs under the prescription drug benefit.	$20 per specialist visit

Infertility services — *Continued on the next page*

Infertility services *(Continued)*	**You pay**
Not covered: • *Reversal of voluntary, surgically-induced sterility.* • *Treatment for infertility when the cause of the infertility was a previous sterilization.* • *Injectable fertility drugs are not covered.* • *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, such as in vitro fertilization* and *embryo transfer including, but not limited to, GIFT and ZIFT.*	*All charges*
Allergy care	
Testing and treatment Allergy injection **NOTE**: You pay the applicable copay for each doctor visit. Each visit to a nurse for an injection only you pay nothing.	$15 per PCP visit $20 per specialist visit Nothing for a visit to a nurse
Allergy serum	Nothing
Treatment therapies	
• 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 29. • Respiratory and inhalation therapy • Dialysis — Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy — Home IV and antibiotic therapy • Growth hormone therapy (GHT) **NOTE**: Growth hormone is covered under Medical Benefits, office copay applies. **NOTE**: We will only cover GHT when we preauthorize the treatment. Call 1-800-245-1206 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services Requiring Our Prior Approval in Section 3.	$20 per specialist visit

Physical, pulmonary and occupational therapies	You pay
• Two consecutive months per condition, beginning with the first day of treatment for each of the following: – Qualified physical therapies – Occupational therapy – Pulmonary rehabilitation **NOTE**: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient rehabilitation is covered under Hospital/Extended Care Benefits. • 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 visit Nothing during a covered inpatient admission
Not covered: • *Long-term rehabilitative therapy.*	*All charges*
Speech therapy	
• Two consecutive months per condition, beginning with the first day of treatment.	$20 per visit, Nothing during a covered inpatient admission
Hearing services (testing, treatment, and supplies)	
• Covered for audiological testing and medically necessary treatment for hearing problems.	$15 per PCP visit $20 per specialist visit
Not covered: • *Hearing aids, testing and examinations for them.*	*All charges*

Vision services (testing, treatment, and supplies)	You pay
• Treatment of eye diseases and injury	$15 per PCP visit $20 per specialist visit
• Corrective eyeglasses and frames or contact lenses (hard or soft) per 24 month period.	All charges over $100
• Routine eye refraction based on the following schedule: – If member wears eyeglasses or contact lenses: Age 1 through 18 — once every 12-month period Age 19 and over — once every 24-month period – If member does not wear eyeglasses or contact lenses: To age 45 — once every 36-month period • Age 45 and over — once every 24-month period refractions **NOTE**: See *Preventive Care, Children,* for eye exams for children.	$20 per specialist visit
Not covered: • *Fitting of contact lenses* • *Eye exercises* • *Radial keratotomy and other refractive surgery*	*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 more information.	$15 per PCP visit $20 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* • *Podiatric shoe inserts*	*All charges*

Orthopedic and prosthetic devices	You pay
• External prosthetic devices which replace all or part of an internal or external body organ or an external body 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, defibrillator, surgically implanted breast implant following mastectomy, and lenses following cataract removal. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. **NOTE**: Coverage includes repair and replacement when due to growth or normal wear and tear.	Nothing
Not covered: • *Orthopedic and corrective shoes not attached to a covered brace* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports*	*All charges*
Durable medical equipment (DME)	
Rental or purchase, including replacement, repair and adjustment, of durable medical equipment prescribed by your Plan Physician, such as oxygen equipment. Under this benefit, we also cover: • Hospital beds • Wheelchairs • Crutches • Walkers • Insulin pumps **NOTE**: Some DME may require precertification by you or your physician.	Nothing
Not covered: • *Elastic stockings and support hose* • *Bathroom equipment such as bathtub seats, benches, rails and lifts* • *Home modifications such as stairglides, elevators, and wheelchair ramps*	*All charges*

Home health services	You pay
• 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 intravenous therapy and medications.	Nothing
Not covered: • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative*	*All charges*
Chiropractic care	
Chiropractic services up to 20 visits per calendar year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electric muscle stimulation, vibratory therapy and cold pack application	$20 per specialist visit
Not covered: Any services not listed above	*All charges*
Alternative treatments	
No benefits	*All charges*
Educational classes and programs	
• Asthma • Diabetes • Congestive heart failure • Low back pain • Coronary artery disease Also see the Non-FEHB page for our Member Health Education, Informed Health Line and Intelihealth.	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 charges associated with the facility (i.e. hospital, surgical center, etc.)
- YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • 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 the HMO. • Insertion of internal prosthetic devices. See 5(a) — Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns **NOTE**: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$15 per PCP office visit, $20 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*

Reconstructive surgery	You pay
• 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 lymphedema; – 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
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*
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; • Medically necessary surgical treatment of TMJ; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Removal of bony impacted wisdom teeth; • Excision of tumors and cysts • Other surgical procedures that do not involve the teeth or their supporting structures.	$20 per specialist visit
Not covered: • *Dental implants* • *Dental care involved with the treatment of temporomandibular joint dysfunction*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: Single — Double • Pancreas • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas • Skin • Tissue • Allogeneic (donor) bone marrow 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 doctor and plan 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 determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor, to the extent these services are not covered by another plan or program. **Limited Benefits** — Treatment for breast cancer, multiple myeloma and epithelial ovarian cancer may be provided in an NCI- or NHI-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. **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
Not covered: • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in — • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
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.	$100 per day up to a maximum of $300 per admission
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 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

Inpatient hospital — *Continued on the next page*

Inpatient hospital *(Continued)*	**You pay**
Not covered: Blood and blood derivatives, except blood clotting factors, and the storage of the patient's own blood for later administration.	*All charges*
Not covered: • *Custodial care, rest cures, domiciliary or convalescent cares* • *Personal comfort items, such as telephone and television*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Radiologic procedures, diagnostic laboratory tests, and X-rays when associated with a medical procedure being done the same day • Pathology Services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if 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.	$75 per day
Services not associated with a medical procedure being done the same day, such as: • Mammogram • Radiologic procedures • Heart catheterization	$20 per specialist visit
Not covered: Blood and blood derivatives, except blood clotting factors, and the storage of the patient's own blood for later administration.	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Extended care benefit: All necessary services during confinement in a skilled nursing facility with a 90-day limit per calendar year when full-time nursing care is necessary and the confinement is medically appropriate as determined by a Plan doctor and approved by the Plan.	Nothing
Not covered: custodial care	*All charges*

Hospice care	You pay
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
Ambulance	
• Ambulance service ordered or authorized by a Plan doctor	Nothing
Not covered: Ambulance services for routine transportation to receive outpatient or inpatient services.	*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	
• Emergency care at a doctor's office	$15 per PCP visit $20 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.	$75 per visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office	$20 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.	$75 per visit

Emergency outside our service area — *Continued on the next page*

Emergency outside our service area *(Continued)*	You pay
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.*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. Air ambulance may be covered. Prior approval is required. See 5(c) for non-emergency service.	Nothing for covered care
Not covered: air ambulance without prior approval	*All charges*

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

Network Benefit

IMPORTANT

Parity

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

Here are some important things 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	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. **NOTE**: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$20 per visit
• Diagnostic tests	$20 per visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment	$20 per outpatient visit
Inpatient service: • Approved residential treatment facility • Hospital services	$100 per day up to a maximum of $300 per admission

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

Mental health and substance abuse benefits *(Continued)*	You pay
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*

Preauthorization

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

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

Limitation

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

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 medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Certain drugs require your doctor to get precertification from the Plan before they can be prescribed under the Plan. Upon approval by the Plan, the prescription is good for the current calendar year or a specified time period, whichever is less.

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 participating pharmacy and request direct reimbursement from us, we will review your claim to determine whether the claim is covered under the terms and conditions of your benefit. 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. We cover nonformulary drugs when prescribed by a Plan doctor at a 50% copayment. For covered nonformulary drugs you pay 50% of the negotiated rate for the drug between the Plan and the participating retail or mail order pharmacy. 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 medication through mail order. A generic equivalent will be dispensed if available, unless your physician specifically requires a name brand.
- **Why use generic drugs?** Generics contain the same active ingredients in the same amounts as their brand name counterparts and must have been approved by the FDA. By using generic drugs, when available, most members see cost savings, without jeopardizing clinical outcome or compromising quality.
- **When you have to file a claim.** Send your itemized bill(s) to: Aetna U.S. Healthcare, Pharmacy Management, Claim Processing, P.O. Box 398106, Minneapolis, MN 55439-8106.

Prescription drug benefits — *Begin on the next page*

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician or dentist and obtained from a Plan pharmacy or through our mail order program: • Drugs for which a prescription is required by Federal law • Oral contraceptive drugs	$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
• Insulin • Disposable needles and syringes need to inject covered prescribed medication, including insulin • Diabetic supplies limited to lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips	$20 per covered brand name formulary prescription/refill (up to a 30 day supply) or $40 for a 31- to 90-day supply through mail order
• Contraceptive drugs and devices • Oral fertility drugs • Intravenous fluids and medications for home use, implantable drugs, such as Norplant, IUDs and some injectable drugs are covered under Medical and Surgical benefits. See Section 5(a) for details.	50% of the negotiated rate between the Plan and the participating retail or mail order pharmacy per covered non-formulary (generic or brand) prescription/refill.
Limited benefits	
• Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits	50%
• Depo Provera is limited to 5 vials per calendar year	$20 copay per vial
• One diaphragm per calendar year	$20 per diaphragm
Here are some things to keep in mind about our prescription drug program: • A generic equivalent may be dispensed if it is available, and where allowed by law. • To request a copy of the Aetna U.S. Healthcare Medication Formulary Guide, call 1-800-537-9384. The information in the Medication Formulary Guide is subject to change. Please visit our website at **www.aetnaushc.com/feds** for current Medication Formulary Guide information.	

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

Covered medications and supplies *(Continued)*	**You pay**
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*

Section 5 (g). Special Features

Feature	Description
Services for the deaf and hearing-impaired	1-800-628-3323
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.
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	The Aetna U.S. Healthcare Moms-to-Babies Maternity Management Program™ helps members give their babies a healthy start with educational materials and services that complement covered benefits. This program includes nurse case management, educational materials, one prenatal and one newborn home nurse visit, breast feeding information and support, and other benefits.
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.
- Your selected Plan primary care dentist 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	You pay
Service	
Diagnostic	
Office visit for oral evaluation — limited to 2 visits per year	$5
Bitewing x-rays — limited to 2 sets of bitewing x-rays per year	$5
Entire x-ray series — limited to 1 entire x-ray series in any 3 year period	$5
Periapical x-rays and other dental x-rays — as necessary	$5
Diagnostic models	$5
Preventive	
Prophylaxis (cleaning of teeth) — limited to 2 treatments per year	$5
Topical fluoride — limited to 2 courses of treatment per year and to children under age 18	$5
Oral hygiene instruction	$5
Restorative (Fillings)	
Amalgam (primary) 1 surface	$5
Amalgam (primary) 2 surfaces	$5
Amalgam (primary) 3 surfaces	$5
Amalgam (primary) 4 surfaces	$5
Amalgam (permanent) 1 surface	$5
Amalgam (permanent) 2 surfaces	$5
Amalgam (permanent) 3 surfaces	$5
Amalgam (permanent) 4 surfaces	$5

Dental Benefits — *Continued on the next page*

Dental Benefits *(Continued)*	You pay
Service	
Prosthodontics Removable	
Denture adjustments (complete or partial/upper or lower)	$5
Endodontics	
Pulp cap — direct	$5
Pulp cap — indirect	$5

NOTE: The above services are only covered when provided by your selected participating primary care dentist in accordance with the terms of your Plan. *If rendered by a participating specialist, they are provided at reduced fees. Pediatric dentists are considered specialists.* Certain other services will be provided by your selected participating primary care dentist at reduced fees. A partial list appears below. Ask your selected participating 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 selected 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 selected participating primary care dentist or participating dental specialist for the specific fee in your area.

Service	You pay up to a maximum fee of
Diagnostic	
Sealant — per permanent tooth	$35
Space maintainer	$560
Restorative (Fillings)	
Resin (anterior) 1 surface	$110
Resin (anterior) 2 surfaces	$145
Resin (anterior) 3 surfaces	$175
Resin (anterior) 4 or more surfaces or incisal angle	$190
Metallic inlay	$725
Prosthodontics, removable	
Complete denture, (upper or lower)	$1,025
Immediate denture (upper or lower)	$1,110
Partial denture resin base (upper or lower)	$790
Partial denture cast metal framework with resin base (upper or lower)	$1,200
Denture repairs	$150
Add tooth to existing partial	$135
Add clasp to existing partial	$150

Dental benefits — *Continued on the next page*

Dental Benefits *(Continued)*	
Service	**You pay up to a maximum fee of**
Prosthodontics, removable *(Continued)*	
Denture rebase	$375
Denture relines	$325
Interim denture (complete or partial/upper or lower)	$465
Tissue conditioning	$110
Prosthodontics, fixed	
Bridge pontic	$875
Metallic inlay/onlay	$815
Cast metal retainer for resin bonded prosthesis	$315
Crown porcelain	$860
Crown cast	$865
Recement bridge	$85
Post and core	$315
Oral surgery	
Extractions (nonsurgical and tissue impacted)	$475
Anesthesia (general in office, first half-hour session)	$270
Periodontics (Gum treatment)	
Gingivectomy per quadrant	$315
Gingival curretage per quadrant	$150
Periodontal surgery	$760
Provisional splinting	$160
Scaling and root planing per quadrant	$150
Periodontal maintenance procedure	$110
Endodontics (Root canal)	
Therapeutic pulpotomy	$125
Root canals (anterior, bicuspid, molar) excluding final restoration	$760
Apicoectomy — anterior	$510
Orthodontics	
Pre-orthodontic treatment visit	$350
Fully banded case (adult age 19 and over)	$5,625
Fully banded case (child age 18 and under)	$5,625
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*

When you have to file a claim Send your itemized bills to Aetna U.S. Healthcare, One Imeson Place. 1 Imeson Park Drive, Bldg. 100, Mezz. Floor, Jacksonville FL 32218.

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.

Intelihealth®

InteliHealth.com offers comprehensive health information which is interactive and easy-to-use. Harvard Medical School and the University of Pennsylvania School of Dental Medicine help InteliHealth to provide trusted and credible health information to its users. InteliHealth features include: a Drug Resource Center, Disease and Condition Management tools, Health Risk Assessments, the Harvard Symptom Scout (an interactive symptom checker that provides guidance about a variety of symptoms), Daily Health News and much more.

Vision One®[1]

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

This eyewear discount enriches the routine vision care coverage provided in your health plan, which includes an eye exam from a participating provider. If your health plan also includes coverage for eyewear such as prescription eyeglasses or contact lens, your out-of-pocket expense can be reduced when you use Vision One discount. You may purchase your eyewear at Vision One locations at discounted rates, and your allowance will automatically be applied at point of purchase. You don't have to submit the receipt for reimbursement. Your allowance applies to *prescription* eyeglasses or contact lenses only.

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

Fitness Program

Aetna U.S. Healthcare offers members access to discounted fitness services provided by GlobalFit™. Programs offer Plan participants:

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

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

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

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *Services Requiring Our Prior Approval* on page 16.**

We do not cover the following:

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

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

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

Submit your drug claims to: Aetna U.S. Healthcare, Pharmacy Management, Claim Processing, P.O. Box 398106, Minneapolis, MN 55439-8106

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 3, 1900 E St. NW, Washington, D.C. 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. **NOTE**: If you want OPM to review 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 include a copy of your specific written consent with the review request. **NOTE**: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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

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 or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-537-9384 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

– If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

– You 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for information.

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

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

• The Original Medicare Plan

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

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

We will not waive any of our copayments or 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, or		✔
c) Are a former spouse of an annuitant, or	✔	
d) Are a former spouse of an active employee		✔

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-537-9384.
- **We do not waive costs when you have the Original Medicare Plan —** When Original Medicare is the primary payer, in this case we will not waive out-of-pocket costs.
- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we do not waive any costs when you have Medicare.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan — 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 provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. 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 or deductibles. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in the Medicare managed care plan so we correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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 manage care plan service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for members, eligible dependent 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 illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

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

Medicaid

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

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 17.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 17.

Covered services

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

Custodial care

Any type of care provided according to Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; or c) is a level such that you have reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Custodial Care includes any type of care where the primary purpose is to attend to your daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples include assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by you, the general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in our sole determination is based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, 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 we determine 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 Employees 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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

- **Converting to individual coverage**

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

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage.

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

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

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planing.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- **Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.**
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

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, 2002. 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

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. 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 open season. Your coverage will begin January 1, 2002. 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 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

Temporary Continuation Of Coverage (TCC)

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 may not show all pages where the item appears.

Summary of Benefits for Aetna U.S. Healthcare® — 2002

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $20 specialist	19
Services provided by a hospital: • Inpatient • Outpatient	$100 per day up to a maximum of $300 per admission $75 per visit	31 32
Emergency benefits: • In-area • Out-of-area	 $75 per visit $75 per visit	 35 35
Mental health and substance abuse treatment	Regular cost sharing	37
Prescription drugs	30 day supply: $10 per generic formulary; $20 per brand name formulary; 2 times formulary copay for 31- to 90-day supply through mail order pharmacy; 50% of the negotiated rate between the Plan and the participating retail or mail order pharmacy per covered nonformulary prescription/refill	40
Dental Care	Variable copays	43
Vision Care	$20 copay per visit. Up to $100 reimbursement for eyeglasses or contacts per 24 month period	24
Special Features: Services for the deaf and hearing-impaired, reciprocity benefit, High Risk pregnancies, and Centers of Excellence for transplants/heart surgery/etc.	Contact Plan	42
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $3,000/Family enrollment per year. Copayments and coinsurance towards prescription drugs and dental services do not count towards these limits.	17

2002 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, 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 who are not career postal employees. 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
Arizona: Phoenix and Tucson Areas							
Self Only	WQ1	$77.42	$25.80	$167.73	$55.91	$91.61	$11.61
Self and Family	WQ2	$217.87	$72.62	$472.05	$157.35	$257.81	$32.68
California: Southern California Area							
Self Only	2X1	$71.99	$24.00	$155.99	$51.99	$85.19	$10.80
Self and Family	2X2	$168.17	$56.05	$364.36	$121.45	$199.00	$25.22
Georgia: Atlanta and Athens Areas							
Self Only	2U1	$83.93	$27.98	$181.85	$60.62	$99.32	$12.59
Self and Family	2U2	$220.46	$73.49	$477.67	$159.22	$260.88	$33.07
Nevada: Southern Nevada and Las Vegas Areas							
Self Only	8L1	$84.35	$28.11	$182.75	$60.91	$99.81	$12.65
Self and Family	8L2	$219.14	$73.04	$474.80	$158.26	$259.31	$32.87
New Jersey and Pennsylvania: All of New Jersey and Southeastern Pennsylvania							
Self Only	P31	$97.86	$46.02	$212.03	$99.71	$115.52	$28.36
Self and Family	P32	$223.41	$150.68	$484.06	$326.47	$263.75	$110.34

2002 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
Washington: Western and Southeast Washington Areas							
Self Only	8J1	$83.05	$27.68	$179.94	$59.98	$98.27	$12.46
Self and Family	8J2	$215.93	$71.98	$467.86	$155.95	$255.52	$32.39