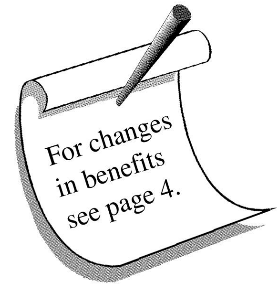
Aetna U.S. Healthcare® 2000

A Health Maintenance Organization



Enrollment in this Plan is limited; see page 6 for requirements.

Serving: Southwestern and Central Pennsylvania

Enrollment code:

KL1 High Option Self Only
KL2 High Option Self and Family

KL4 Standard Option Self Only
KL5 Standard Option Self and Family

Serving: Southeastern Pennsylvania

Enrollment code:

SU1 High Option Self Only
SU2 High Option Self and Family

SU4 Standard Option Self Only
SU5 Standard Option Self and Family

Serving: New Jersey

Enrollment code:

P31 High Option Self Only
P32 High Option Self and Family

P34 Standard Option Self Only
P35 Standard Option Self and Family

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

Enrollment code:

JN1 High Option Self Only
JN2 High Option Self and Family

JN4 Standard Option Self Only
JN5 Standard Option Self and Family

Special Notice: Code JN no longer covers the cities of Colonial Heights, Hopewell, Petersburg, and Richmond; and the counties of Amelia, Charles City, Chesterfield, Dinwiddie, Goochland, Hanover, Henrico, King William, New Kent, Nottaway, Powhattan, Prince George, Surry and Sussex. You must select a new plan. If you do not select a new plan your benefits will be limited to emergency care. Members enrolled in V8 are now enrolled in JN, High Option.

Visit the OPM website at www.opm.gov/insure and this
Plan's website at www.aetnaushc.com/feds

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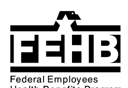
Personnel Management



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Introduction

Aetna U.S. Healthcare, Inc.
1425 Union Meeting Road
P.O. Box 3013
Blue Bell, PA 19422

This brochure describes the benefits you can receive from Aetna U.S. Healthcare under its contract (CS1766) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000 and are shown on page 4. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Aetna U.S. Healthcare as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not rewritten the Benefits section of this brochure. You will find new benefits language next year.

How To Use This Brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.
4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. General exclusions — Things we don't cover. Look here to see benefits that we will not provide.
7. Limitations — Rules that affect your benefits. This section describes limits that can affect your benefits.
8. FEHB FACTS. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible, OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information.)

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- Code JN is now part of this brochure. Please review the brochure for your benefits.
- The service area for code JN no longer covers the cities of Colonial Heights, Petersburg and Richmond; and the counties of Amelia, Charles City, Chesterfield, Dinwiddie, Goochland, Hanover, Henrico, King William, New Kent, Nottaway, Powhattan, Prince George, Surrey and Sussex.
- Members enrolled in V8 are now enrolled in JN.
- Under Standard Option, you now pay a $240 copay per hospital medical admission and a $50 copay per outpatient surgical visit.
- Under Standard Option, for prescription drugs, you now pay a $10 copay for generic formulary, a $15 copay for brand-name formulary and a $30 copay for nonformulary drugs, per prescription, up to a 30-day supply.
- Under High Option, for prescription drugs, you now pay a $5 copay for generic formulary, a $10 copay for brand-name formulary and a $25 copay for nonformulary drugs, per prescription, up to a 30-day supply.

- Diaphragms now require a $10 copay under High Option and a $15 copay under Standard Option.
- Under High and Standard Option, all prescriptions over 30 days must be filled through the mail order program. Up to a 90-day supply is available. You pay two times the copay amount required for a 30-day supply.
- You now receive up to a $100 reimbursement per 24-month period for corrective eyeglasses and frames or contact lenses.
- The maximum fees you pay for various dental procedures has changed. See page 23.
- All oral fertility drugs are now covered under the Prescription Drug Benefit.
- You now pay a 50% copay per prescription for drugs used to treat sexual dysfunction.
- Pennsylvania, Code KL. Your share of the Standard Option non-postal premium will decrease by 3.1% for Self Only and decrease by 3.2% for Self and Family. Your share of the High Option non-postal premium will increase by 5.7% for Self Only and decrease by 4.0% for Self and Family.
- Pennsylvania, Code SU. Your share of the Standard Option non-postal premium will increase by 15.0% for Self Only and increase by 20.8% for Self and Family. Your share of the High Option non-postal premium will increase by 17.9% for Self Only and decrease by 5.0% for Self and Family.
- New Jersey, Code P3. Your share of the Standard Option non-postal premium will increase by 16.8% for Self Only and increase by 35.8% for Self and Family. Your share of the High Option non-postal premium will decrease by 3.6% for Self Only and increase by 6.9% for Self and Family.
- Maryland, Washington DC and Northern Virginia, Code JN. Your share of the Standard Option non-postal premium will increase by 13.4% for Self Only and increase by 13.2% for Self and Family. Your share of the High Option non-postal premium will increase by 26.1% for Self Only and increase by 32.0% for Self and Family.

Section 3. How to get benefits

What is this Plan's service area?

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

Pennsylvania

2/97
This service has full accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

Serving: Southwestern, Central and Northeastern Pennsylvania

Enrollment Code:

KL1 High Option Self Only
KL2 High Option Self and Family

KL4 Standard Option Self Only
KL5 Standard Option Self and Family

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

12/96
This service has full accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

Serving: Southeastern Pennsylvania

Enrollment Code:

SU1 High Option Self Only
SU2 High Option Self and Family

SU4 Standard Option Self Only
SU5 Standard Option Self and Family

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

New Jersey

12/97
This service has full accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

Serving: All of New Jersey

Enrollment Code:

P31 High Option Self Only
P32 High Option Self and Family

P34 Standard Option Self Only
P35 Standard Option Self and Family

The State of New Jersey

Maryland/DC/ Virginia

4/97
This service has full accreditation from the NCQA. See the *FEHB Guide* for more information on NCQA.

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

Enrollment Code:

JN1 High Option Self Only
JN2 High Option Self and Family

JN4 Standard Option Self Only
JN5 Standard Option Self and Family

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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay for emergency care.

- If you need to visit a participating primary care physician for a covered service, and you are 50 miles or more away from home, you may visit a primary care physician from our Plan's approved HMO network: Call 1-800-537-9384 for provider information and location.
- Select a doctor from three primary care doctors in that area.
- The Plan will authorize you for one visit and any tests or X-rays ordered by that primary care physician.
- You must coordinate all subsequent visits through your own participating primary care physician.
- Under High Option you must pay a $10 copay for each visit. Under Standard Option you must pay a $15 copay for each visit.

You are eligible for this benefit for the first 30 days you are away from home.

If you or a covered family member move outside of our service area, you can enroll in another plan. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services.

After you pay $1,500 in copayments or coinsurance for one family member, or $3,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs and dental services do not count toward these limits, and you must continue to make these payments.

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

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.

When you first join the Plan, you must choose a primary care doctor for you and each covered member of your family. You may select your primary care physician from a list of family or general practitioners, pediatricians or medical internists. For women, open access to Plan participating gynecologists is available for the diagnosis and treatment of gynecological problems and one routine gynecological exam and Pap smear each calendar year.

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 1-800-537-9384. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist.

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.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide 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.

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

The Plan's medical policy review group uses the Hays Medical Technology Assessment Service, HCFA's policy manual, FDA decisions, etc., to determine which medical procedures are experimental and/or investigational.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life-threatening condition and you haven't responded to my request for service?

Call us at 1-800-537-9384 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life-threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division IV at 202-606-0737 between 8 a.m. and 5 p.m. Serious or life threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division IV, P.O. Box 436, Washington, DC 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code, allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Third Party 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. Once you have completed the external review process, you can use OPM's review process as detailed in this section.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits and, within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate.

High Option — You pay a $10 copay per visit at your primary doctor office, specialist office, or for laboratory tests and X-rays; $15 copay for a doctor's house call, and nothing for home visits by nurses and health aids.

Standard Option — You pay a $15 copay per visit at your primary doctor office, specialist office, or for laboratory tests and X-rays; $20 copay for a doctor's house call, and nothing for home visits by nurses and health aids.

The following services are included and are subject to the office visit copay:

- Preventive care, including well-baby care and periodic checkups.
- Mammograms are covered as follows: for women age 35 through 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters.
- Consultations by specialists.
- Diagnostic procedures, including laboratory tests and X-rays.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor (after the first visit, office visit copays are waived for obstetrical care). The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services, including Norplant implantations and IUD insertions.
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum).
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, heart-lung, lung (single and double), skin, tissue, kidney, liver and pancreas transplants; 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. Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

- Dialysis.
- Chemotherapy, radiation therapy, and inhalation therapy.
- Surgical treatment of morbid obesity.
- Durable medical equipment, such as wheelchairs and hospital beds, orthopedic devices, such as braces, and prosthetic devices, such as artificial limbs, external breast prosthesis and surgical bra following a mastectomy and lenses following cataract removal are covered. Prosthetic devices which are worn externally and replace all or part of an internal body organ or an external body part are covered. Coverage includes repair and replacement when due to growth or normal wear and tear. Replacement, repairs and maintenance not provided for under a manufacturer's warranty or purchase agreement will be covered.
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor who will periodically review the program for continuing appropriateness and need.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts and removal of bony-impacted wisdom teeth. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech, occupational, and pulmonary) is provided on an outpatient basis for up to two consecutive months per condition if beginning with the first day of treatment, significant improvement can be expected; **you pay** a $10 copay under High Option and a $15 copay under Standard Option per visit. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient rehabilitation is covered under Hospital/Extended Care Benefits.

Diagnosis and treatment of infertility, including artificial insemination, are covered; **you pay** a $10 copay under High Option and a $15 copay under Standard Option per visit. The following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI). Coverage is for 6 cycles. Oral fertility drugs are covered under the Prescription Drug Benefit. Injectable fertility medications are not covered. Artificial insemination must be preauthorized. Member must contact the Infertility Case Manager at 1-800-575-5999 for approval. Services not listed are not covered.

Cardiac rehabilitation on an outpatient basis following angioplasty, cardiovascular surgery, congestive heart failure, or a myocardial infarction, is covered for up to three visits a week for a total of 18 visits; **you pay** a $10 copay under High Option and a $15 copay under Standard Option per visit.

Chiropractic services are provided for up to 20 visits per calendar year; **you pay** a $10 copay under High Option and a $15 copay under Standard Option per visit.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel.
- Immunizations and boosters for travel or work-related exposure.
- Reversal of voluntary, surgically induced sterility.
- Treatment for infertility when the cause of the infertility was a previous sterilization.
- Infertility treatment when the FHS level is greater than 19 mIU/ml.
- The purchase, freezing and storage of donor sperm and donor embryos.
- Assisted reproductive technologies (ART) procedures not shown, such as in vitro fertilization and embryo transfer including, but not limited to, GIFT and ZIFT.
- Surgery primarily for cosmetic purposes.
- Homemaker services.
- Hearing aids.
- Transplants not listed as covered.
- Long-term rehabilitative therapy.
- Foot orthotics.
- Dental implants.
- 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.

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor.

High Option — You pay nothing.

Standard Option — You pay $240 copay per medical admission and a $50 copay per outpatient surgical visit.

All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care.
- Specialized care units, such as intensive care or cardiac care units.

Extended care

The Plan provides a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** nothing. All necessary services are covered, including;

- Bed, board and general nursing care.
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited Benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 20 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television.
- Blood and blood derivatives, except blood derived clotting factors, and the storage of the patient's own blood for later administration.
- Custodial care, rest cures, domiciliary or convalescent care.

Emergency Benefits

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 the Plan may determine are medical emergencies — what they all have in common is the need for quick action.

Emergencies within the Service Area

If you are in an emergency situation, please call your 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.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

Plan pays…

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay…

$10 under High Option and $15 under Standard Option per after hours doctor's visit; $35 under High Option or Standard Option per hospital emergency room or outpatient department visit, or per urgent care center visit for emergency services that are covered benefits of this plan. If the emergency results in admission to a hospital, the copay is waived.

Emergencies outside the 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-Plan providers must be approved by the Plan or provided by Plan providers.

Plan pays…

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay…

$10 under High Option and $15 under Standard Option per after hours doctor's visit; $35 under High Option or Standard Option per hospital emergency room or outpatient department visit, or per urgent care center visit for emergency services that are covered benefits of this plan. If the emergency results in admission to a hospital, the copay is waived.

What is covered

- Emergency care at a doctor's office or an urgent care center.
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services.
- Ambulance service approved by the Plan.

What is not covered

- Elective care or nonemergency 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.

Filing claims for non-Plan providers

With your authorization, the Plan will pay emergency benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 10.

Mental Conditions/ Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, this Plan provides the following services necessary to the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders:

- Diagnostic evaluation.
- Psychological testing.
- Psychiatric treatment (including individual and group therapy).
- Hospitalization (including inpatient professional services).

Outpatient care

Up to 40 outpatient visits to Plan doctors, consultants or other psychiatric personnel per calendar year; **you pay** the following for up to 40 visits — all charges thereafter:

High Option	Standard Option
Visits 1 and 2 — Nothing	Visits 1–40 — a $25 copay per visit
Visits 3–10 — a $10 copay per visit	
Visits 11–40 — a $25 copay per visit	

Inpatient care

Up to 35 days of hospitalization per calendar year; **you pay** nothing for the first 35 days — all charges thereafter. Inpatient days may be exchanged for outpatient treatment at a rate of four outpatient visits or two partial treatment days for each inpatient day when approved by the Plan.

What is not covered

- Care for psychiatric conditions which in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with the mental conditions benefit shown above. Outpatient visits to Plan mental health providers for follow-up care and counseling are covered, as well as inpatient services necessary for diagnosis and treatment. The mental conditions visit/day limitations and copays apply.

What is not covered

Treatment that is not authorized by a Plan doctor.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Participating Plan Pharmacy will be dispensed for up to a 30-day supply.

High Option — You pay a $5 copay for generic formulary drugs, a $10 copay for brand name formulary drugs and a $25 copay for nonformulary drugs per prescription unit or refill.

Standard Option — You pay a $10 copay for generic formulary drugs, a $15 copay for brand name formulary drugs and a $30 copay for nonformulary drugs per prescription unit or refill.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The Plan's formulary does not exclude medications from coverage, but requires a higher copayment for nonformulary drugs. Nonformulary drugs will be covered when prescribed by a Plan doctor. Certain drugs require your doctor to get precertification from the Plan before they can be prescribed under the Plan.

Members must obtain a 31- to 90-day supply of prescription medication through mail order. **You pay** two times the amount of your 30-day supply copay.

To obtain a 31- to 90-day supply by mail order:

- Call 1-800-537-9384 to obtain the necessary forms.
- Mail the prescription for a 31- to 90-day supply, along with the appropriate copay, to the Mail Order Pharmacy.

Covered medications and accessories of the pharmacy benefit include:

- Drugs for which a prescription is required by Federal law.
- Oral contraceptive drugs.
- Insulin.
- Disposable needles and syringes needed to inject covered prescribed medication, including insulin.
- Diabetic supplies limited to lancets, alcohol swabs, urine test strips/tablets, and blood glucose test strips.
- Oral fertility drugs.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galectosemia, and homocystinuria when administered under the direction of a Plan doctor.

Intravenous fluids and medications for home use, implantable drugs, such as Norplant, IUDs and some injectable drugs are covered under Medical and Surgical Benefits.

Limited benefits

- Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. **You pay** 50% copay under High Option and Standard Option up to the dosage limits and all charges above that.
- Depo Provera, limited to five vials per calendar year. **You pay** a $10 copay under High Option and a $20 copay under Standard Option.

Additional benefits

- One diaphragm per calendar year. **You pay** a $10 copay under High Option and $15 copay under Standard Option.
- Drugs obtained at a nonparticipating pharmacy for an out-of-area emergency are reimbursed at 100% of the cost of the prescription, less the applicable copay. Reimbursements are subject to professional review.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available.
- Drugs obtained at a non-Plan pharmacy.
- Vitamins and nutritional substances that can be purchased without a 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).

Other Benefits

Dental care

What is covered

High Option and **Standard Option** — The following dental services are covered when provided by your Plan primary care dentist. If you should require additional dental services, your primary care dentist will provide these services at reduced fees. A partial list appears below. Please consult your participating dentist for a complete schedule of current reduced member fees. All member fees must be paid directly to the participating dentist. Note: Each employee and dependent must select a primary care dentist from the directory and include the name on the enrollment or provider selection form. Benefits are only payable if performed by your primary care dentist you have selected or a participating specialist. **You pay** a $5 copay per visit for the following procedures:

DIAGNOSTIC
Oral evaluations
All X-rays
Diagnostic models

PREVENTIVE
Prophylaxis (cleaning of teeth) every 6 months
Topical fluoride — every 6 months (child under age 18)
Oral hygiene instruction

RESTORATIVE (Fillings)
Amalgam (primary) 1 surface
Amalgam (primary) 2 surfaces
Amalgam (primary) 3 surfaces

RESTORATIVE (Fillings) ***continued***
Amalgam (primary) 4 surfaces
Amalgam (permanent) 1 surface
Amalgam (permanent) 2 surfaces
Amalgam (permanent) 3 surfaces
Amalgam (permanent) 4 surfaces

PROSTHODONTICS REMOVABLE
Denture adjustments (complete or partial/ upper or lower)

ENDODONTICS (Root Canal)
Pulp cap — direct
Pulp cap — indirect

The following procedures are available from your Plan primary care dentist. These same services received from a Plan specialist may require you to pay a fee that is higher than the stated maximum. Call your Plan primary care dentist or Plan dental specialist for the specific fee in your area.

	You pay up to a maximum
DIAGNOSTIC	
Sealant — per permanent tooth	$35
Space maintainer	$445
RESTORATIVE (Fillings)	
Resin (anterior) 1 surface	$85
Resin (anterior) 2 surfaces	$115
Resin (anterior) 3 surfaces	$140
Resin (anterior) 4 or more surfaces or incisal angle	$150
Metallic inlay	$580
PROSTHODONTICS REMOVABLE	
Complete denture (upper or lower)	$820
Immediate denture (upper or lower)	$885
Partial denture resin base (upper or lower)	$630
Partial denture cast metal framework with resin base (upper or lower)	$955
Denture repairs	$120
Add tooth to existing partial	$105
Add clasp to existing partial	$120
Denture rebase	$300
Denture relines	$260
Interim denture (complete or partial/ upper or lower)	$370
Tissue conditioning	$85
PROSTHODONTICS FIXED	
Bridge pontic	$685
Metallic inlay/onlay	$650

	You pay up to a maximum
PROSTHODONTICS FIXED *(continued)*	
Cast metal retainer for resin bonded prosthesis	$250
Crown porcelain	$685
Crown cast	$690
Recement bridge	$65
Post and core	$250
ORAL SURGERY	
Extractions (nonsurgical and tissue impacted)	$380
Anesthesia (general in office, first half-hour session)	$215
PERIODONTICS (Gum Treatment)	
Gingivectomy per quadrant	$250
Gingival curettage per quadrant	$120
Periodontal surgery	$605
Provisional splinting	$125
Scaling and root planing per quadrant	$120
Periodontal maintenance procedure	$85
ENDODONTICS (Root Canal)	
Therapeutic pulpotomy	$100
Root canals (anterior, bicuspid, molar) excluding final restoration	$605
Apicoectomy — anterior	$405
ORTHODONTICS (Braces)	
Pre-orthodontic treatment visit	$280
Fully banded case (adult age 19 and over)	$4,400
Fully banded case (child age 18 and under)	$4,400

What is not covered

Services not received from a participating dental provider.

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, the Plan provides the following vision care benefits when received from Plan providers.

- Routine eye refraction based on the schedule below, including a written lens prescription. **You pay** a $10 copay under High Option and a $15 copay under Standard Option.
- If member wears eyeglasses or contact lenses, an eye refraction may be obtained as follows:

  Member age 1 through 18 — once every 12-month period.
  Member age 19 and over — once every 24-month period.

- If member does not wear eyeglasses or contact lenses, an eye refraction may be obtained as follows:

  Member to age 45 — once every 36-month period.
  Member age 45 and over — once every 24-month period.

- Up to $100 reimbursement per 24-month period for corrective eyeglasses and frames or contact lenses (hard or soft lenses).

What is not covered

- Eye exercises.
- Fitting of contact lenses.

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Member Health Management

Our wellness and preventive programs provide you with access to materials and services to promote, in conjunction with advice from your physician, a healthy lifestyle and good health.

The **Healthy Eating™ Program** is an easy-to-follow approach to better health through good nutrition. It's designed to provide members and their families with information to develop a long-term healthful eating plan that is also realistic. Members will also understand how to lower the amount of fat in their diets and become more physically active.

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

Vision Care

You are eligible to receive substantial discounts on eyeglasses, contact lenses and nonprescription items such as sunglasses and contact lens solutions through the **Vision One® Program** (1-800-793-8616) at more than 6,000 locations across the country.

This discount enriches our routine vision care coverage, which includes an eye exam from a participating provider. Additionally, it may include coverage for a portion of the cost of prescription eyeglasses or contact lenses.

National Medical Excellence Program®

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, Aetna U.S. Healthcare will arrange and pay for your care as well as related travel expenses to wherever the necessary care is available.

Medicare Prepaid Plan Enrollment

This Plan offers Medicare recipients (except for those enrolled in code JN) the opportunity to enroll in the Plan through Medicare. As indicated on page 26, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-832-2640 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-832-2640 for information on the benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract.

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 or condition.

We do not cover the following:

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

Section 7. Limitations — Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 25.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

TRICARE

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

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800-537-9384, or write to 1425 Union Meeting Road, P.O. Box 3013, Blue Bell, PA 19422. You may also contact us by fax at 215-775-5870, or visit our website at www.aetnaushc.com/feds.

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premiums effective?

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

What happens when I 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, which is described later in this section.

What types of coverage are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Are my medical and claims records 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.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage.

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees* from your employing or retirement office.

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce.
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an 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 if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

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 or write:

THE HEALTH CARE FRAUD HOTLINE
202-418-3300

U.S. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Aetna U.S. Healthcare — 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	High option pays/provides	Page	Standard option pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	16	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** a $240 copay per medical admission and a $50 copay per outpatient surgical visit	16
	Extended care	All necessary services, no dollar or day limit. **You pay** nothing	16	All necessary services, no dollar or day limit. **You pay** nothing	16
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 35 days of inpatient care per calendar year. **You pay** nothing	20	Diagnosis and treatment of acute psychiatric conditions for up to 35 days of inpatient care per calendar year. **You pay** nothing	20
	Substance abuse	Covered under Mental Conditions benefit	20	Covered under Mental Conditions benefit	20
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per visit (after the first visit, office visit copays are waived for the maternity care); $15 copay per house call by a doctor	13	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $15 copay for primary care or specialist care per visit (after the first visit, office visit copays are waived for the maternity care); $20 copay per house call by a doctor	13
	Home health care	All medically necessary visits by nurses and health aides. **You pay** nothing per visit	14	All medically necessary visits by nurses and health aides. **You pay** nothing per visit	14
	Mental conditions	Up to 40 outpatient visits per calendar year. **You pay** the following Visits 1 and 2 — covered in full Visits 3–10 — a $10 copay per visit Visits 11–40 — a $25 copay per visit	20	Up to 40 outpatient visits per calendar year. **You pay** a $25 copay per visit	20
	Substance abuse	Covered under Mental Conditions benefit	20	Covered under Mental Conditions benefit	20
Emergency care		Reasonable charges for services required because of a medical emergency. **You pay** a $10 copay after hours at a primary doctor's office; a $35 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan	18	Reasonable charges for services required because of a medical emergency. **You pay** a $15 copay after hours at a primary doctor's office; a $35 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan	18
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay for generic formulary drugs, a $10 copay for brand name formulary drugs, and a $25 copay for nonformulary drugs per prescription unit or refill. **You pay** two times the amount of your 30-day supply copay for prescriptions filled through mail order.	21	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $10 copay for generic formulary drugs, a $15 copay for brand name formulary drugs, and a $30 copay for nonformulary drugs per prescription unit or refill. **You pay** two times the amount of your 30-day supply copay for prescriptions filled through mail order.	21
Dental care		Preventive dental care, comprehensive range of restorative, orthodontic and other services. **You pay** variable copays	23	Preventive dental care, comprehensive range of restorative, orthodontic and other services. **You pay** variable copays	23
Vision care		Routine refraction and up to $100 for eyeglasses or contact lenses per 24-month period; **you pay** a $10 copay per visit	24	Routine refraction and up to $100 for eyeglasses or contact lenses per 24-month period; **you pay** a $15 copay per visit	24
Out-of-pocket maximum		Copayments are required for a few benefits; however, after you pay $1,500 in copayments or coinsurance for one family member, or $3,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. Copayments or coinsurance for prescription drugs and dental services do not count towards these limits.	7	Copayments are required for a few benefits; however, after you pay $1,500 in copayments or coinsurance for one family member, or $3,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. Copayments or coinsurance for prescription drugs and dental services do not count towards these limits.	7

2000 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 most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in, "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2 to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium Biweekly		**Non-Postal Premium Monthly**		**Postal Premium A Biweekly**		**Postal Premium B Biweekly**	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
All of New Jersey									
High Option Self Only	P31	$78.83	$57.96	$170.80	$125.58	$93.06	$43.73	$93.26	$43.53
High Option Self and Family	P32	$175.97	$179.64	$381.27	$389.22	$207.74	$147.87	$201.02	$154.59
Standard Option Self Only	P34	$76.42	$25.47	$165.57	$55.19	$90.43	$11.46	$90.43	$11.46
Standard Option Self and Family	P35	$175.97	$92.09	$381.27	$199.53	$207.74	$60.32	$201.02	$67.04
Southeastern Pennsylvania									
High Option Self Only	SU1	$78.83	$36.98	$170.80	$80.12	$93.06	$22.75	$93.26	$22.55
High Option Self and Family	SU2	$175.97	$119.87	$381.27	$259.72	$207.74	$88.10	$201.02	$94.82
Standard Option Self Only	SU4	$74.24	$24.74	$160.85	$53.61	$87.84	$11.14	$87.84	$11.14
Standard Option Self and Family	SU5	$175.97	$79.64	$381.27	$172.55	$207.74	$47.87	$201.02	$54.59
Southwestern, Central and Northeastern Pennsylvania									
High Option Self Only	KL1	$68.21	$22.73	$147.78	$49.26	$80.71	$10.23	$80.71	$10.23
High Option Self and Family	KL2	$175.97	$66.07	$381.27	$143.15	$207.74	$34.30	$201.02	$41.02
Standard Option Self Only	KL4	$57.31	$19.10	$124.17	$41.39	$67.81	$8.60	$67.81	$8.60
Standard Option Self and Family	KL5	$152.85	$50.95	$331.18	$110.39	$180.87	$22.93	$180.87	$22.93

		Non-Postal Premium Biweekly		Non-Postal Premium Monthly		Postal Premium A Biweekly		Postal Premium B Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Maryland, Washington, DC, and Northern Virginia									
High Option Self Only	JN1	$78.83	$29.37	$170.80	$63.63	$93.06	$15.14	$93.26	$14.94
High Option Self and Family	JN2	$175.97	$77.33	$381.27	$167.55	$207.74	$45.56	$201.02	$52.28
Standard Option Self Only	JN4	$56.02	$18.67	$121.37	$40.46	$66.29	$8.40	$66.29	$8.40
Standard Option Self and Family	JN5	$131.40	$43.80	$284.70	$94.90	$155.49	$19.71	$155.49	$19.71

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