HEALTHGUARD

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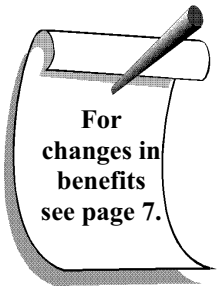
HealthGuard CEQ

2001

A Health Maintenance Organization



Serving: Southeastern and Southcentral Pennsylvania

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

This Plan has commendable accreditation from the NCQA. See the 2001 Guide for more information on NCQA.

Enrollment codes for this Plan:

NQ1 Self Only
NQ2 Self and Family

Authorized for distribution by the:

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

FEHB — Federal Employees Health Benefits Program

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Table of Contents

Introduction

HealthGuard
280 Granite Run Drive
Lancaster, PA 17601

This brochure describes the benefits of HealthGuard under our contract (CS 2232) 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.

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. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 4. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Section 1 - Facts about this HMO plan

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

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

When you receive services from 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

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.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, 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.

- HealthGuard has been incorporated since 1984, resulting in 15 years of operation.
- November 23, 1999, HealthGuard received a Commendable accreditation status from the National Committee for Quality Assurance (NCQA).

HealthGuard consists of an extensive network of hospitals, ambulatory surgical centers, highly qualified primary care physicians, highly qualified specialists, and various other ancillary providers.

If you want more information about us, call 800/822-0350, or write to HealthGuard, 280 Granite Run Drive, Lancaster, PA 17601. You may also contact us by fax at 717/581-4580 or visit our website at www.hguard.com.

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: Lancaster, York, Cumberland, Dauphin, Lebanon, and Berks counties in Pennsylvania.

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, urgent care, or HealthGuard advised Centers of Excellence care.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. HMO-USA is a network of Blue Cross Blue Shield physicians that participate with HealthGuard throughout the United States. Should you have an urgent, emergent need for a physician (non-life-threatening) which cannot wait to be treated until you return home, you call 1-800-4-HMO-USA. For temporary living arrangements outside of our service area, you can access HMO-USA through HealthGuard's Member Services 717-560-3353 or 800-822-0350. 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 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to copays and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing or shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling HealthGuard Member Services at 800-822-0350, or checking our website at www.hguard.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 10.9% for Self Only or 10.9% for Self and Family.
- We cover a licensed certified nurse midwife if the midwife works under a Plan obstetrician's supervision.
- We cover cardiac rehabilitation for up to eighteen (18) visits. We may approve additional visits (up to 18) if they are medically necessary for continued monitoring. Limitations apply.
- We clarified ambulance service to show that we cover specially equipped vehicles used to transport the acutely sick or injured to a local hospital. We cover services provided by an advanced life support unit and ground or air transportation. Limitations apply.
- You pay a $20 specialist copay for all outpatient medical, mental and substance abuse services.
- You pay $10 for generic or $20 for brand drugs for each prescription or refill.

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 800-822-0350.

Where you get covered care

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

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

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

What you must do

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. Your first step as a HealthGuard member will be to choose a Primary Care Physician from the HealthGuard network of providers.

- **Primary care**

Your primary care physician can be a Family Practice Physician, and Internist, or a Pediatrician. Your primary care physician will provide 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. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see obstetricians and gynecologists 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 work with the specialist and the plan to 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.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-822-0350. 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 pre-certification. Your physician must obtain pre-certification for the following services, such as: Breast Reconstruction Mammoplasty, Cardiac Rehabilitation, Chiropractic, Cosmetic Procedures, Dental Procedures, Durable Medical Equipment, Infertility – diagnostics, drugs, treatments, etc., Out-of-Network referrals, Sclerotherapy, Sinus Surgery, TMJ issues, and UPPP (laser).

To obtain information on pre-authorization from HealthGuard, call the Member Services Department at 800-822-0350 or 717-560-3353 or send an email message to members@hguard.com.

Section 4 - Your costs for covered services

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

• **Copayments**	A copayment is a fixed amount of money you pay to the provider when you receive services. Example: When you see your primary care physician you pay a copayment of $10 per office visit.
Your out-of-pocket maximum for Copayments	We do not have an out-of-pocket maximum.

Section 5 - Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 58 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. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800-822-0350 or at our website at www.hguard.com.

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 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	$10 per office visit to your primary care physician $20 per office visit to a specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion	$10 per office visit to your primary care physician $20 per office visit to a specialist
At home	$10 per visit from your primary care physician $20 per visit from a specialist

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit, otherwise $10 per office visit.

Preventive care, adult	You pay
Routine screenings, such as:, • Blood lead level – One annually • Total Blood Cholesterol – once every three (3) years, ages 19 through 64 (at age 3 if a family history exists) • Colorectal Cancer Screening, including •• Fecal occult blood test •• Sigmoidoscopy, screening – every three years starting at age 50 • annual physical	$10 per office visit
Prostate Specific Antigen (PSA test)	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment Services*, above.	$10 per office visit to your primary care physician $20 per office visit self-referred to a participating OB-Gyn office
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	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
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 for all adults at risk	$10 per office visit

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Examinations, such as: •• Eye screenings through age 17 to determine the need for vision correction. •• Ear screenings through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per visit when performed in Primary Care doctor's office
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 page xx for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • 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).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	**You pay**
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit to your primary care physician $20 per office visit to a specialist

Family Planning continued on next page.

Family planning *(Continued)*	**You pay**
Not covered: Coverage for reversal of voluntary sterilization is excluded.	*All charges.*
Infertility services	**You pay**
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• Intravaginal insemination (IVI) •• Intracervical insemination (ICI) •• Intrauterine insemination (IUI)	\$10 per office visit \$20 per office visit to a specialist
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Fertility Drugs except Clomid (see prescription drug benefits page 39)*	*All charges.*
Allergy care	**You pay**
Testing and treatment Allergy injection	\$10 per office visit \$20 per office visit to a specialist
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We will only cover GHT when we pre-certify the treatment. Call 800-447-0597 for pre-certification. 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.	$10 per office visit to your primary care physician $20 per office visit to a specialist

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy -- • 60 visits or 60 days whichever comes first, per condition for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. • Cardiac Rehabilitation - a graded exercise program under continuous observation and with periodic monitoring of cardiac response when deemed Medically Necessary for patients with a high-risk medical condition defined by the HealthGuard Cardiac Rehabilitation policy. Covered Benefits are limited to eighteen (18) visits with a possibility of eighteen (18) additional visits if a medical reason exists for continued monitoring.	$10 office visit copay $20 per office visit to a specialist

Rehabilitative therapies continued on next page.

Rehabilitative therapies *(Continued)*	**You pay**
Not covered: • Treatment of developmental delay, apraxic disorders and other academic related problems, unless caused by injury or episodic illness; • The treatment of stuttering, speech delay, accent reduction, delays in speech development (unless resulting from illness, injury, surgery, or congenital defects); • Voice therapy, speech problems resulting from psychoneurotic or personality disorders; • Articulation problems not caused by an acute illness or injury; • Aquatic therapy; • Equestrian therapy; • Recreation therapy; • Work hardening; • Massage therapy; • Orthoptic therapy (visual therapy); • Music therapy; • Infant stimulation; • Patterning therapy (except for newborn children); • Cognitive therapy; • Multi-modality clinics; • Other therapies not within the scope of the definition of short-term rehabilitation therapy. • Therapy to maintain an already achieved level of function.	*All charges.*
Hearing services (screening, treatment, and supplies)	**You pay**
• Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit to Primary Care Physician
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (screening, treatment, and supplies)	**You pay**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit $20 per office visit to a specialist

Vision services continued on next page.

Vision services (screening, treatment, and supplies) *(Continued)*	**You pay**
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care)	$10 per office visit $20 per office visit to a specialist
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *Eye exercises and orthoptics* • *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 information on podiatric shoe inserts.	$10 per office visit $20 per office visit to a specialist
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)*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Externally worn breast prostheses and surgical bras; including necessary replacement, following a mastectomy; • The purchase, fitting, necessary adjustment and repairs of Medically Necessary Orthotic Devices prescribed by a Plan PCP and authorized in advance by HealthGuard. • Custom molded foot Orthotics is limited to one pair per calendar year. • A replacement of an Orthotic Device is covered only if there has been a sufficient change in the Member's physical condition that makes the original device no longer functional. • The purchase, fitting, necessary adjustment, repairs and replacements of Prosthetic Devices that replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances) as a result of Illness or Injury or congenital defects. Such devices require a written prescription by a Plan Provider and must be authorized in advance by HealthGuard. Instruction and appropriate services required for the Member to properly use the item (such as attachment or insertion) are covered. Expenses incurred as a result of the misuse, negligence or loss or a prosthetic appliance are not covered.	*Nothing*
• *Not covered:* • *orthopedic and corrective shoes* • *arch supports* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered* • *Expenses incurred as a result of the misuse, negligence or loss or a prosthetic appliance.*	*All charges.*
Durable medical equipment (DME)	**You pay**
Durable Medical Equipment shall mean equipment which is primarily and customarily used to serve a medical purpose; can withstand repeated use; generally is not useful to a person in the absence of Illness or Injury; and is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be Durable Medical Equipment. (Examples include: wheelchairs and hospital beds)	*Nothing*

Durable medical equipment (DME) continued on next page.

Durable medical equipment *(Continued)*	**You pay**
Not covered: • *Motorized wheel chairs*	*All charges.*
Home health services	
• Home health care ordered by Plan Physician and provided by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.), or Home Health Aide. • Services include Oxygen Therapy, Intravenous Therapy, and Medications. The following services and supplies for Home Health Care are covered when prescribed by the Plan PCP, determined to be Medically Necessary by HealthGuard, and provided by a Plan Home Health Care Agency. Pre-certification must be obtained from HealthGuard. HealthGuard shall not be required to provide benefits for Home Health Care services when HealthGuard determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care or member is not home bound. Home Health Care services include: • Professional services of a registered nurse (R.N.) or licensed practical nurse provided that such nurse does not ordinarily reside in the Member's home or is not a member of the Member's immediate family. • Physical Therapy, Occupational Therapy, and Speech Therapy. • Medical and surgical supplies provided by the Home Health Agency. • Medical social service consultation. • Dietician services. • Home medical equipment.	*Nothing*
Not covered: • Home Health Care benefits will not be provided for homemaker services, Custodial Care, and food or home delivered meals. No payment will be made for services provided by a non-Plan Home Health Agency or not preauthorized by HealthGuard	All charges.

Alternative treatments	
Acupuncture – by a Plan Provider up to a maximum of thirty (30) visits per calendar year. Acupuncture will be covered for chronic pain syndrome when prescribed by a HealthGuard pain specialist as part of a comprehensive pain program provided by a plan MD or DO. Chiropractic Care –for Medically Necessary treatment of acute sciatica, back or neck pain, provided by a chiropractor who is a Plan Provider upon a Referral by a Plan Primary Care Physician, for up to twenty (20) visits per calendar year. Biofeedback Therapy –Medically Necessary biofeedback therapy for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, when provided by a Plan Provider. If more conventional treatments are not successful, treatment for incapacitating muscle spasm or weakness is covered when part of a comprehensive pain management program provided by a Plan Provider.	$10 Primary Care Physician office visit copay $20 per office visit to a specialist
Not covered: • naturopathic services • hypnotherapy • Maintenance therapy for chronic conditions is excluded.	All charges.
Educational classes and programs	
Classes include: • Weight Management, • Smoking Cessation, • Diabetes Management, • Childbirth. Please contact HealthGuard Member Services department at 800-822-0350 for more information.	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 your care.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Any costs associated with the facility charge (i.e. hospital, surgical center, etc.) are covered in Section 5 (c).
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
1. Treatment of fractures, including casting	1. $20 per office visit to a specialist
2. Normal pre- and post-operative care by the surgeon	2. Nothing
3. Correction of amblyopia and strabismus	3. Nothing
4. Endoscopy procedure	4. $20 per office visit to a specialist
5. Biopsy procedure	5. $10 PCP; $20 per office visit to a specialist
6. Removal of tumors and cysts	6. Nothing
7. Correction of congenital anomalies (see reconstructive surgery)	7. Nothing
8. Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	8. Nothing
9. 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	9. Nothing

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • 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.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*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.
	Nothing

Reconstructive surgery continued on next page.

Reconstructive surgery *(Continued)*	**You pay**
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See above.
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, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate; or severe functional maloclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts; and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures	$10 per office visit $20 per office visit to a specialist
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplant • 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 Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.	*Nothing*
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$10 per office visit $20 per office visit to a specialist

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 care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).

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.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	**You pay**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives not replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	**You pay**
Some of HealthGuard's Plan Hospitals provide sub-acute facility care.	Nothing

Extended care benefits/skilled nursing facility benefits continued on next page.

Extended care benefits/skilled nursing facility benefits *(Continued)*	**You pay**
Skilled nursing facility (SNF): Services and supplies, including room and board, provided during an admission at a Plan Skilled Nursing Facility are Covered Services for 180 days only if all of the following conditions are met: • The member's Plan PCP recommends the Skilled Nursing Facility admission; and • The admission is for recovery from an Illness or Injury upon release from a prior Hospital stay, or the admission is in place of a Hospital stay that would be required in the absence of these services or supplies; and • The Member is under the continuous care of his or her Plan PCP or a Plan Physician providing services at the direction of such Plan PCP; and • The Member's Plan PCP certifies that he or she needs skilled nursing care twenty-four (24) hours a day; and • The Member's admission is not for Custodial Care or respite care; and the request for admission is pre-certified by HealthGuard In the event a Member elects to remain in the Skilled Nursing Facility after the date that the Member's Plan PCP and/or HealthGuard has determined and notified the Member that the Member no longer meets the criteria for continued Inpatient confinement, the Member shall be fully responsible for payment for all services and supplies provided by the Skilled Nursing Facility, physicians and/or other Providers after such date of notification. HealthGuard shall not be financially responsible for any such service and supply provided after such date of notification.	Nothing
Not covered: custodial care	*All charges*

Hospice care	
Hospice shall mean an establishment which furnishes palliative care and supportive services only to Members who have a medical condition and prognosis of less than six (6) months to live and which is staffed and equipped to: • Provide care either in the home or in a facility, or both, for persons who do not require the full services of a Hospital or Skilled Nursing Facility; and • Offer medial services under the direction of a physician and a continuous twenty-four (24) hour registered nursing staff; and • Provide directly or by arrangement, social psychological or spiritual services for the Member and his/her family. **Covered Services**. Hospice care bereavement and pastoral counseling services for Member who has been determined to be terminally ill by the Member's Plan PCP are covered only if each service or supply is furnished by a Plan Provider within six (6) months from the date when the terminally ill Member entered the Hospice care program, is provided pursuant to a Referral by the Member's Plan PCP and is pre-certified by HealthGuard. Services may include home and Hospital visits by nurses and social workers, pain management and symptom control, instruction and supervision of a family Member, Inpatient care, counseling and emotional support; and other Home Health Care services. Hospice care benefits are limited to a Maximum of thirty (30) days of Inpatient care in a Plan Hospice facility and one hundred eighty (180) days of in-home care, per Member per lifetime.	Nothing
Not Covered: • funeral arrangements, • financial or legal counseling, • homemaker or caretaker services, • any service not solely related to the care of the Member, • Sitter or companion services for the Member or other Members of the family, • transportation, • house cleaning, • services and supplies provided during periods of remission, • maintenance of the house.	*All charges*

Ambulance	
• Covered Benefits are provided for ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the acutely sick and Injured from a Member's home or scene of the accident or Emergency to a Hospital. • To be covered, the transportation must be to the closest institution that can provide Covered Services appropriate to the Member's condition. If there is no Participating facility in the local area that can provide Covered Services appropriate to the Member's condition,, the transportation must be to the closest facility outside the local area that can provide the necessary service. • Covered Benefits are also available for Emergency Services actually provided by an advanced life support unit even though the unit does not provide transportation. Special ground or air transportation will be covered when deemed Medically Necessary by HealthGuard.	Nothing
Not Covered: • Routine transportation between facilities and/or office sites.	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:

Availability. Covered Benefits are provided for Emergency Services and Urgent Care twenty-four (24) hours per day, seven (7) days per week, subject to the following conditions and limitations.

No Pre-Certification. Pre-Certification is not required for Emergency Services.

Plan Hospital. Urgent Care must be provided at a Plan Hospital, except in such instances where a Member's medical condition would be jeopardized if treatment is delayed or when the Member experiences symptoms requiring Urgent Care while outside of the Service Area.

Emergencies within our service area:

Professional and Hospital Services. Urgent Care and/or Emergency Services.

- Urgent Care must be arranged by the Member's Plan PCP and authorized in accordance with HealthGuard's policies and procedures. **FAILURE TO COMPLY WITH THIS SECTION MAY RESULT IN NON-PAYMENT OF SERVICES PROVIDED.**
- The Member may obtain Emergency Services from the closest Provider. Emergency Services do not require prior contact with the Member's Plan PCP. However, the Member or the Provider of the Emergency Services shall use their best efforts to contact the Member's Plan PCP and authorized care according to HealthGuard's policies and procedures.
- If care is Medically Necessary and appropriate, a Hospital emergency room visit will be covered. An emergency room Copayment is payable by a Member unless the Member has been referred to an emergency room by a Plan Primary Care Physician or by HealthGuard. Copayments will be waived if the Member is hospitalized directly from the emergency room.
- If a Member is admitted to a Plan Hospital for Inpatient Emergency Services, the Provider of Emergency Service must contact the Member's Plan PCP within forty-eight (48) hours or the next business day, whichever is later, unless it was not reasonable possible to do so. **FAILURE TO COMPLY MAY RESULT IN NON-PAYMENT OF SERVICES PROVIDED.**
- If contact is not made within the designated time frame(s), HealthGuard will only be financially responsible for services provided after the date of notification, provided the medical condition meets HealthGuard's Medically Necessity review criteria.

Emergencies outside our service area:

Professional and Hospital Services. A Member will be entitled to benefits for Urgent Care and/or Emergency Services received outside the Service Area provided: (1) delay in receipt of such services until the Member could access services at a Plan facility would jeopardize his/her life or health, and (2) the Member could not reasonably have been able to anticipate the need for such services prior to having to access care or prior to leaving the Service Area.

- Urgent Care should be arranged by the Member's Plan PCP and authorized in accordance with HealthGuard's policies and procedures. If contact with the Member's Plan PCP cannot be made prior to receiving the Urgent Care services, the Member must notify the Member's Plan PCP as soon as reasonably possible following the urgent care service.

- The Member may obtain Emergency Services from the closest Provider. Emergency Services do not require prior contact with the Member's Participating PCP. However, the Member or the Provider of the Emergency Services shall use their best efforts to contact the Member's Plan PCP within twenty-four (24) hours or treatment and released, unless it was not reasonable possible to do so. All follow-up services must be arranged by the Member's Plan and authorized according to HealthGuard's policies and procedures.

- If care was Medically Necessary and appropriate, a Hospital emergency room visit will be covered. An emergency room Copayment is payable by a Member unless the Member has been referred by a Plan Primary Care Physician or by HealthGuard. Copayments shall be waived if the Member is hospitalized directly from the emergency room.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25, waived if admitted
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	**You pay**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25, waived if admitted
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	**You pay**
• Covered Benefits are provided for ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the acutely sick and Injured from a Member's home or scene of the accident or Emergency to a Hospital. • To be covered, the transportation must be to the closest institution that can provide Covered Services appropriate to the Member's condition. If there is no Plan facility in the local area that can provide Covered Services appropriate to the Member's condition,, the transportation must be to the closest facility outside the local area that can provide the necessary service. • Covered Benefits are also available for Emergency Services actually provided by an advanced life support unit even though the unit does not provide transportation. • Special ground or air transportation will be covered when deemed Medically Necessary by HealthGuard. Routine transportation between facilities and/or office sites are not covered.	Nothing
Not Covered: • Routine transportation between facilities and/or office sites	All Charges

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

Network Benefit

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for 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 PREAUTHRIZATION OF THESE SERVICES**. See the instructions after the benefits description below.

Benefit 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 office visit

Network mental health and substance abuse benefits -- Continued on next page.

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	$20 per (visit or test)
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *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 follow your treatment plan and all the following authorization processes:

For access, please contact Magellan at 800-332-1024.

Special transitional benefit

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

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause,
- If changes to this plan's benefit structure for 2001 cause your out-of-pocket costs for your out-of-network provider to be greater than they were in year 2000.

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

Limitation

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

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription – or – A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **We use a formulary.** HealthGuard has an open formulary with a preferred list of medications. A drug formulary is a listing of products that an organization such as a hospital or an HMO considers the preferred medications for patient use. HealthGuard's formulary is for outpatient drug therapy. The products listed are considered to be the most effective in both health outcome and cost in each therapeutic category. The formulary is a guide for physicians for medication use. The Plan's drug formulary is reviewed monthly by the Medical Policy and Technology Committee. The committee consists of the Plan's Medical Director and ten community physicians who have direct input into the decisions of the committee. The committee's goal is to develop appropriate utilization of prescription medication while maintaining cost controls. New drugs and therapies that become available, as well as existing drugs and therapies, are reviewed for safety, therapeutic value and cost. Based on these factors, drugs are added or deleted from the formulary.
- **These are the dispensing limitations.** The retail and mail order prescription drug benefit operates with the following quantities/limitations: Maximum Day Supply is 34 days; Maximum Unit Supply is 100 units; Mail Service – Maximum Day Supply is 90 days; Mail Service – Maximum Unit Supply is unlimited. Copayments for Generic Drugs are $10 for a 34-day supply and for Brand Name Drugs are $20 for a 34-day supply. Prior authorizations are required for injectables (except for imitrex, insulin, lovenex), those medications that exceed $500 in cost, Claritin (physician needs to establish medical necessity), and xenical.
- **When you have to file a claim.** Please call HealthGuard Member Services at 800-822-0350 to request a form to be sent to Advance ParadigM (HealthGuard's Prescription Benefit Manager).

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
Covered medications and accessories include: • Drugs for which a prescription is required by law • Oral and injectable contraceptive drugs; contraceptive diaphragms • Insulin, with a copay charge applied to each vial • Disposable needles and syringes needed to inject covered prescribed medication, including insulin • Glucose test strips for diabetics, when prescribed by a Plan doctor • Allergy serum • Intravenous fluids and medication for home use and Depo Provera are covered under Medical and Surgical Benefits. • Ostomy bags and wafers (365 per calendar year per member)	$10 copayment for Generic Drugs per 34-day supply $20 copayment for Brand Name Drugs per 34-day supply Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
• Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. You pay the applicable copayment up to the dose limits and all charges above that.	

Covered medications and supplies continued on next page.

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. • We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800-822-0350.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines*	*All Charges*

Section 5(g) - Special Features

Feature	Description
Centers of excellence for transplants/heart surgery/etc	Centers of Excellence are any Hospital or facility designated by HealthGuard at which HealthGuard will authorize payment for covered transplant services and covered complex surgical procedures for Members.
Travel benefit/ services overseas	Members who are approved by HealthGuard to receive Transplants from a transplantation center more than 150 miles from their home will be entitled to the following travel benefits provided if their residence is located within the HealthGuard Service Area: • Transportation, by the most appropriate means, for the Member from his or her home to the transplantation center at the time of transplant. • Transportation and temporary housing for the Member and one caregiver to accompany the Member for evaluation and pre- and post-transplantation care which must be delivered at the transplantation center. Lodging expense is limited to a Maximum of $100.00 per day unless approved in advance by HealthGuard. • Food and other miscellaneous expenses are not reimbursable. • Total lifetime reimbursement for transplantation-related travel expenses is limited to $10,000.00.

Section 5(h) - Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your 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

Description	You Pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$10 office visit Copay $20 office visit to a specialist
Dental Benefits	

We have no other dental benefits.

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

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

HealthGuard's Fitness Club Reimbursement Benefit.

We feel that it is important to encourage our members, ages 18 and above, to adopt a healthy lifestyle. Physical fitness has been shown to lower the risks of certain diseases, such as heart disease.

We wish to encourage those who have been in a program to continue with your program and for those who have not yet begun a program to get started. We strongly encourage you to see your physician before beginning any exercise program, especially if you have cardiovascular risk factors such as high blood pressure, high cholesterol, sedentary lifestyle, tobacco use or a family history of heart disease.

HealthGuard has designated specific Health and Fitness Clubs to participate in the Cardiovascular Disease Reduction Fitness Program. These clubs have met specific criteria that are essential to participate in this program.

There are several changes in the fitness requirements as outlined in the Question & Answer section to follow.

HOW DO I QUALIFY FOR THE NEW FITNESS REIMBURSEMENT PROGRAM?

- You must be a current HealthGuard member at the time of joining the health and fitness club and at the time of reimbursement.
- You must be eligible under your HealthGuard plan for the fitness reimbursement program.
- You must be a member of HealthGuard and a member of the HealthGuard Designated Health and Fitness Club for 12 consecutive months beginning January 1, 1999, to submit an application.
- You must participate in the fitness program for a minimum of 104 visits.

Wellness Programs

As a Plan participant, you and all covered family members are eligible to participated in various programs that promote better health. The class program topics include weight management, diabetic education, heart/blood pressure, childbirth classes and cholesterol management. The Plan pays the full amount for the cost of each approved class. Member Services must be contacted in order to register for the approved classes. For more information on the various classes available, call Member Services at 717-560-3353 or toll-free at 800-822-0350.

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.**

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;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; 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.

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 Prescription 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 800-822-0350.
When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: HealthGuard, 280 Granite Run Drive, Lancaster, PA 17601

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: HealthGuard, 280 Granite Run Drive, Lancaster, PA 17602; 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 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 medical provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

The Disputed Claims Process (Continued)

Send OPM the following information:

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

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

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

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

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

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or precertification/prior approval, then call us at 800-447-0597 and we will expedite our review; or

(b) We denied your initial request for care or precertification/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.

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 healthcare expenses without regard to fault. This is called "double coverage."

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

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

The Original Medicare Plan

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

(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		✓

- **Claims process Plan and Medicare**

You probably will never have to file a claim form when you have both our

- 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 800-822-0350. [web too, etc]

We waive some costs when you have Medicare -- When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

- Medical services and supplies provided by physicians and other health care professionals.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. 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 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.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare+Choice service area.

TRICARE

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

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

Medicaid

When other Government agencies are responsible for your care

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

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 11.

Covered services

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

Custodial care

Care, including room and board, that a) does not require the skills of technical or professional personnel on a daily basis; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of Skilled Nursing Facility care; or c) is at a level such that the Member has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, or using the toilet; changing dressings of non-infected, post operative or chronic conditions; preparation of special diets; supervision of medication which can be self-administered by the Member; general maintenance care of colostomy or ileostomy; residential care and adult day care; protective and supportive care including educational services, rest cures and convalescent care.

Experimental or investigational services

Procedures not in accordance with generally accepted medical practice are not covered. Prescription drugs and medications are not covered unless they are prescribed in accordance with the Food and Drug Administration guidelines.

Us/We

Us and we refer to HealthGuard

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 remarry.

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

- **TCC**

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

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

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

- **Converting to individual coverage**

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/822-0350 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 are no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

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

Summary of benefits for the *HealthGuard* - 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by 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: $10 primary care; $20 specialist	13
Services provided by a hospital: • Inpatient..... • Outpatient	Nothing	29 30
Emergency benefits: • In-area..... • Out-of-area	$25 (waived if admitted to the hospital)…. $25 (waived if admitted to the hospital)….	35 35
Mental health and substance abuse treatment	Regular cost sharing.	37
Prescription drugs	$10 Generic for 34-day supply $20 Brand for 34-day supply	39
Dental Care	No Benefit	43
Vision Care	No benefit	19
Special Features ..... • Wellness Programs and Fitness Club Reimbursement		44

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2001 Rate Information for HealthGuard

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

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

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

		Non-Postal Premium				***Postal Premium***	
		Biweekly		**Monthly**		**Biweekly**	
Type of Enrollment	**Code**	Gov't Share	Your Share	Gov't Share	Your Share	**USPS** Share	**Your** Share
Location Information							
High Option Self Only	**NQ1**	**$69.23**	**$23.08**	**$150.01**	**$50.00**	**$81.93**	**$10.38**
High Option Self & Family	**NQ2**	**$180.55**	**$60.18**	**$391.19**	**$130.39**	**$213.65**	**$27.08**