NYLCARE
An Aetna U.S. Healthcare Company

NYLCare Health Plans of the Mid-Atlantic, Inc.

1999

A Health Maintenance Organization

Serving: Washington, DC, Baltimore, MD and
Fredericksburg/Richmond/Tri-cities, VA metro areas

Enrollment in this Plan is limited; see page 9 for requirements.

Enrollment code:

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

This plan has full accreditation from the NCQA. See the FEHB Guide for more information on NCQA

Visit the OPM website at http://wwwopm.gov/insure and this Plan's website at http://wwwnylcare.com

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73–067

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Inside Front Cover

NYLCare Health Plans of the Mid-Atlantic, Inc.

NYLCare Health Plans of the Mid-Atlantic, Inc., 7601 Ora Glen Drive, Greenbelt, MD, 20770, has entered into a contract (CS 1884) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical Plan herein called NYLCare Health Plans of the Mid-Atlantic, NYLCare, or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the benefits stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each Plan annually. Benefit changes are effective January 1, 1999, and are shown on page 22 of this brochure.

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CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation — sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 301/441-1600, 800/635-3121, TDD 301/441-4535 or 800/522-7128 and explain the situation.
- If the matter is not resolved after speaking to your Plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member, or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other Plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM, to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on pages 14 and 15** . If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See “If you are hospitalized when you change Plans” on page 3.

FEHB Plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a Plan under the FEHB Program.

General information *continued*

If you are hospitalized when you change Plans

If you change Plans or options, benefits under your prior Plan or option cease on the effective date of your enrollment in your new Plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior Plan or option. In that case, the confined person will continue to receive benefits under the former Plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior Plan or option, or (3) the 92nd day after the last day of coverage under the prior Plan or option However, benefits for other family members under the new Plan will begin on the effective date. If your Plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new Plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed Plans or Plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB Plan is not entitled to receive benefits under any other FEHB Plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage, and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid Plan when one is available in your area. If you later change your mind and want to re-enroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid Plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid Plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the Plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid Plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid Plans (also known as Coordinated Care Plans Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid Plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program, nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service, or when family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following :

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because of separation from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any Plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to non-group coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage, when they may convert to non-group coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium pay ments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees - Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children - You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs; for example, the child reaches age 22 or marries. **Former spouses** - You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available - or chosen - when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, non-group contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the Plan in which you are enrolled within 31days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e. g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of Creditable coverage

Under the Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Facts about this Plan

This Plan is a comprehensive medical Plan, sometimes called a health maintenance organization (HMO). When you enroll in an HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. Benefits are available only from Plan providers except during a medical emergency. **Members are required to select a personal doctor from among participating Plan primary care doctors** . Services of a specialty care doctor can only be received by referral from the selected primary care doctor except as discussed under the section "Role of a primary care doctor." There are no claim forms when Plan doctors are used.

Your decision to join an HMO should be based on your preference for the Plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change Plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at 301/441-1600, 800/635-3121, TDD 301/441-4535 or 800/522-7128, or you may write the Carrier at 7601 Ora Glen Drive, Greenbelt, MD 20770. You may also contact the Carrier by fax at 301/489-5288 or 301/489-5287, or at its website at **http://www .nylcare.com.**

Information that must be made available to you includes:

- 1997 FEHB Disenrollment rates for the Plan.
- Compliance with State and Federal licensing or certification requirements and the dates they were met. If noncompliant, the reason for non-compliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Who provides care to Plan members?

NYLCare Health Plans of the Mid-Atlantic is an individual practice prepayment Plan (IPP) offering coordinated services through more than 13,500 private practice doctors, hospitals, and other health care providers. Each member may choose his or her own primary care doctor from the Plan's participating primary care doctors listed in the provider directory. When you choose a primary care physician in an individual practice, you receive covered care from medical specialists (including hospitals) from the entire network of providers. When you choose a primary care physician in a group practice or physicians association, you receive covered care from participating specialists and hospitals associated with that group or physician association. If you need covered care that is not available from providers affiliated with your group practice or physicians' association, the Plan will make arrangements for your care. Members must also select one participating Plan family dentist for the entire family under the High Option. Members are not required to select a participating Plan dentist for themselves or their family under the Standard Option, but are required to obtain covered dental services from a participating Plan dentist.

Role of the primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other participating Plan providers are covered only when there has been a referral by the member's primary care doctor, with the following exceptions: a woman may see her Plan gynecologist or certified nurse midwife without a referral for routine gynecological care, including her annual routine examination, as well as pre-natal and post-natal obstetrical care. However, a woman must still receive a referral before receiving covered infertility services and covered outpatient surgical procedures. See the "limited benefits" section of "Medical and Surgical Care" on pages 12 and 13 for further details regarding gynecological care and infertility services. Members may also see their Plan dentist for covered dental care, and their Plan optometrist for covered vision care without a referral. Finally, referrals are also not necessary for pre and post natal office visits after the initial visit.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Facts about this Plan *continued*

Choosing your doctor

The Plan's provider directory lists primary care doctors (family and general practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated and are available at the time of enrollment or upon request by calling the Customer Services Department, 24 hours a day, 365 days per year at 301/441-1600, 800/635-3121, TDD 301/441-4535 or 800/522-7128; you can also find out if your doctor participates with this Plan by calling these numbers. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. **Important note: When you enroll in this Plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider cannot be guaranteed.**

If you enroll, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name(s) of the primary care doctor(s) you select for you and each member of your family. Members may change their doctor selection by notifying the Plan 30 days in advance. If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

Referrals for specialty care

Except in a medical emergency, or when a primary care doctor has designated another doctor to see patients when he or she is unavailable, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if specialists or consultants are required beyond those participating in the Plan, the primary care doctor will make arrangements for appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after completing the consultation(s) or service(s) authorized by the referral. All follow-up care must be provided or arranged by the primary care doctor. On referrals, the primary care doctor will give specific instructions to the specialist or consultant as to what services are authorized. If additional services or visits are suggested by the specialist or consultant, you must first check with your primary care doctor. Do not go to the specialist or consultant until your primary care doctor has made the necessary arrangements and obtained any required Plan authorization for the referral in advance.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan, with you and the Plan, that allows an adequate number of direct access visits with that specialist. The treatment plan will include a referral for a specified number of direct access visits to your specialist without the need to obtain further referrals. The treatment plan for chemotherapy, radiation therapy and dialysis can allow up to six months of authorized visits with a single referral from your primary care doctor.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity of a hospitalization before you may be hospitalized, referred for some specialty care, receive certain services, obtain follow-up care from a specialist, or receive certain categories of prescription drugs. In addition, your Plan doctor must receive Plan authorization before you receive durable medical equipment, orthopedic devices, and prosthetic devices from a Plan vendor.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you prior to your joining this Plan is now your Plan primary care doctor, you need to call and explain that you now belong to this Plan, and ask that a referral form be sent to the specialist for your next appointment.

If you are selecting a new primary care doctor, you must schedule an appointment so the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Facts about this Plan *continued*

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach $650 per Self Only enrollment or $1,500 per Self and Family enrollment under the High Option or $1,000 per Self Only enrollment or $2,500 per Self and Family enrollment under the Standard Option. This copayment maximum does not include costs of dental services, prescription drugs, treatment of infertility, durable medical equipment, prosthetic devices, orthopedic devices, inpatient care of mental conditions/substance abuse, or, under High Option, vision care.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered.

Deductible carryover

If you changed to this Plan during open season from a Plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that Plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old Plan will reimburse these covered expenses. If you have not met it in full, your old Plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old Plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Experimental/ investigational determinations

The Plan's Technology Assessment Program (TAP) uses multiple objective, independent and credible resources to assess the safety and effectiveness of emerging medical technologies and new applications of existing technologies for procedures, treatments, drugs and devices. TAP's resources include the approval status of regulatory agencies, conclusions concerning healthy outcomes, the technology's patient benefit vs. alternatives and the technology's benefit outside investigational settings. The process includes access to a national panel of medical experts associated with academic learning centers. These ombudsmen provide case-specific coverage decisions when needed.

The Plan maintains a Corporate Technology Assessment Committee that uses the resources listed herein to handle both general and individual case assessments. The medical director communicates general guidelines to participating providers. Individual case assessments are based upon criteria consistent with general assessment policy and employ outside ombudsmen when needed.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described below. You must live or work in the service area to enroll in this Plan.

The Plan's service area **is located in the metropolitan areas of Washington, DC, Baltimore, Maryland and Fredericksburg/Richmond/Tri-Cities Virginia, as follows:**

All of Washington, DC; the Maryland counties of Anne Arundel, Baltimore, Calvert, Carroll, Charles, Frederick, Harford, Howard, Prince George's, Montgomery and St. Mary's plus the city of Baltimore; the Virginia counties of Amelia, Arlington, Caroline, Charles City, Chesterfield, Dinwiddie, Fairfax, Fauquier, Goochland, Hanover, Henrico, King George, King William, Loudoun, Louisa, New Kent, Nottoway, Powhattan, Prince George, Prince William, Spotsylvania, Stafford, Surry, Sussex, and Westmoreland, plus the cities of Alexandria, Colonial Heights, Fairfax, Falls Church, Fredericksburg, Hopewell, Manassas, Manassas Park, Petersburg and Richmond.

Facts about this Plan *continued*

Benefits for care outside the service area are limited to emergency services, as described on pages 14 and 15. If you or a covered family member move outside the service area, you may enroll in another approved Plan. It is not necessary to wait until you move, or for the open season, to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

Guest Privileges Program

The Guest Privileges Program allows you and/or your covered dependents to receive guest benefits from another NYLCare Plan (the Guest Plan) if you relocate to that Plan's geographic location for a period of 90 days or more. The region to which you and/or your covered dependents are relocating (the "guest region") must be in an approved FEHB NYLCare service area. By selecting the Guest Privileges Program, you and/or your covered dependents will be covered under the terms of the FEHB contract the Guest Plan provides.

To enroll in the program, fill-out a Guest Privileges Program application and submit it to the Guest Plan. Once your application has been processed, the Guest Plan will send you an enrollment kit, including provider directory and Primary Care Physician (PCP) selection form. You and/or your covered dependents must select a PCP affiliated with the Guest Plan to receive nonemergency care from the Guest Plan. Once the Guest Plan enrollment has been processed, you will receive a NYLCare Guest Privileges ID card and confirmation of your PCP choice. Both your new NYLCare ID card and your PCP selection are valid for the period of your relocation.

Please Note: If you temporarily return home while covered under the Guest Privileges Program and obtain medical care, you will receive approved out-of-area emergency benefits only, since your network access has been transferred to your guest region. Before you return home permanently from the guest region, you must submit another Guest Privileges application. (The Guest Plan's Member Services Department can provide you with the additional application.) You must complete the Return Home Information portion of this Guest Privileges application to transfer your benefits back to your home region. For information regarding the Guest Privileges Program, please contact NYLCare Member Services at (301) 441-1600 or (800) 635-3121, TDD at (301) 441-4535 or (800) 522-7128, or you may write the Plan at 7601 Ora Glen Drive, Greenbelt, MD 20770.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan. This brochure is the official statement of benefits on which you can rely.**

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you need to do, unless your Plan tells you that you need to file a Medicare claim.

General Limitations *continued*

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One Plan normally pays its benefits in full as the primary payer, and the other Plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid Plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U. S. C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar law. If medical benefits provided under such law are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under the Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition** as discussed under Authorization on page 7. The following are excluded:

- Care by non-Plan doctors or hospitals, except for authorized referrals or emergencies (see Emergency Benefits);
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term.

Medical and Surgical Benefits

What is covered

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

High Option - You pay a $5 office visit copay; but no additional copay for laboratory tests and X-rays. **You pay** a $5 house call copay for a doctor's visit, nothing for visits by nurses and health aides. **You pay** a $20 copay for doctor visits or house calls after hours.

Standard Option - You pay a $10 office visit copay; but no additional copay for laboratory tests and X-rays. **You pay** a $10 house call copay for a doctor's visit, nothing for visits by nurses and health aides. **You pay** a $10 copay for doctor visits or house calls after hours.

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

- Preventive care, including well-baby care and periodic health assessments
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor (office visit copays are waived for obstetrical care after the first maternity care visit). The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of the infant requiring definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum); **you pay** a $25 copay per visit for allergy testing and a $5 copay per allergy immunization under **High Option** . **You pay** nothing under **Standard Option** .

- Internal, non-cosmetic prosthetic devices, including permanent aids and supports for defective parts of your body, nonimplantable artificial limbs attached to the body to aid its function or replace a missing part and external lenses following cataract surgery.
- Cornea, heart, kidney, liver, single lung, double lung, heart/ lung, and kidney/ pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer when performed at a Plan Center of Excellence. Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Surgical treatment of morbid obesity
- Chemotherapy, radiation therapy, and inhalation therapy
- Home health services of skilled nurses and health aides, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. **You pay** nothing under **High Option** and **Standard Option** .
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers at no additional cost to you except as noted.

Limited Benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. Treatment of cleft lip and cleft palate is covered for inpatient and outpatient orthodontics, oral surgery, and otologic, autological, and speech/language services if your primary care physician authorizes the services and it is pre-approved by the Plan. If treatment is given in a physician's office, **you pay** , a $5 copay per visit under **High Option,** a $10 copay per visit under **Standard Option.** If treatment requires a hospital admission, the appropriate inpatient copay applies (see page 24). All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Routine gynecological care that can be provided in the gynecologist's office is available without a referral from the member's primary care doctor, except the patient must continue to have infertility services and outpatient surgical procedures coordinated by her primary care doctor. **You pay** a $5 copay under **High Option** and $10 under **Standard Option** per office visit for routine gynecological care and a copay of 50% of covered charges for infertility services under both the **High** and **Standard Option.**

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis. Coverage for physical therapy is limited for up to 60 visits per medical condition. All other short-term rehabilitative therapy (including cardiac rehabilitation), is covered for up to 60 consecutive days per condition, when a Plan doctor determines that the therapy will result in a significant improvement in the member's condition within 60 days of the date of the first treatment. **You pay** a $5 copay per outpatient session under **High Option** and $10 per outpatient session under **Standard Option** . Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Inpatient therapy is covered only if you are receiving other inpatient care at the same time. Inpatient and outpatient services are combined to determine the number of visits or treatment period against the maximum allowable total benefit.

Medical and Surgical Benefits *continued*

Diagnosis and treatment of infertility is covered; **you pay** 50% of covered charges under both options. The following type of artificial insemination is covered: intravaginal insemination (IVI); **you pay** 50% of covered charges under both options. Cost of donor sperm, including preparation and testing, is not covered. Fertility drugs (oral or suppository only) are covered at 50% of charges under both options. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer including, but not limited to GIFT and ZIFT, are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility for up to a maximum of 60 consecutive days; **you pay** a $5 copay per visit under **High Option** , a $10 copay per visit under **Standard Option** .

Durable medical equipment is covered for items such as wheelchairs, equipment for traction, oxygen (including replacements and equipment for its administration), insulin pumps and hospital beds; and **orthopedic devices** such as braces for the legs or back, crutches, walkers, canes, and aids for standing and walking. Durable medical equipment and orthopedic devices are covered when the item is used to support a physiological need; primarily for a medical purpose; appropriate for the patient's specific condition; can be used repeatedly for an indefinite period of time; used in ordinary activities of daily living but not for activities of a recreational or athletic nature. Durable medical equipment may be rented or purchased at the Plan's option. **You pay** 50% coinsurance under **High Option** and **Standard Option** .

Medical and low protein foods is covered for the treatment of inherited metabolic diseases, when prescribed and administered by a Plan doctor. **You pay** nothing.

What is not covered

- Physical examinations or immunizations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary sterilization
- Surgery primarily for cosmetic purposes
- Hearing aids
- Chiropractic services
- Homemaker services
- Transplants not listed as covered
- Repair or duplicates of a prosthetic device, except replacement of an artificial limb due to growth of a child is covered
- Mechanical organ replacement devices such as artificial hearts or left ventricular assist devices
- Repair, duplicates or replacement of durable medical equipment and orthopedic devices.
- Whole blood and concentrated red cells
- Long-term rehabilitative therapy
- Acupuncture, naturopathy and hypnotherapy
- Orthotics

Hospital/Extended Care Benefits

What is covered

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

High Option - you pay nothing.

Standard Option - Subject to annual out-of-pocket maximum, **you pay** $200 copay per medical admission; a $400 copay per surgical or maternity admission; and a $50 copay per outpatient surgical visit.

All necessary services are covered , including:

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

Hospital/Extended Care Benefits *continued*

Extended care

The Plan provides a comprehensive range of benefits for up to 60 days per member per year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** nothing. **All necessary services are covered** , including:

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

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of six months or less. This benefit is limited to 180 days per member. **You pay** nothing.

Ambulance service

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

Limited benefits

Inpatient dental procedures - Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure. The Plan will cover the hospitalization in a participating facility, but not the cost of the professional dental services. The conditions for which hospitalization would be covered include hemophilia and heart disease or when dental care needs to be provided to an individual who meets a specified age, developmental, or emotional criteria. The cost of general anesthesia and associated (participating) hospital or ambulatory facility charges are covered, if prior authorization is received. The dental care must be provided by a Plan specialist in pediatric dentistry or oral and maxillofacial surgery.

Acute inpatient detoxification - Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for non-medical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone, television and personal care kits
- Whole blood and concentrated red cells
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

What is a medical emergency?

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

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Emergency Benefits *continued*

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

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

Plan pays...

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

You pay...

A $20 copay under **High Option** and a $15 copay under **Standard Option** per urgent care center visit; a $20 copay per visit under **High Option** and a $10 copay under **Standard Option** for care rendered by a primary care doctor after normal business hours; a $40 copay under **High Option** and a $25 copay under **Standard Option** per emergency room visit for emergency care services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency copayment is waived and:

High Option - **You pay** nothing.

Standard Option - **You pay** a $200 copay per medical admission; a $400 copay per surgical admission.

Emergencies outside the service area

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Plan pays...

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

You pay...

A $20 copay under **High Option** and a $15 copay under **Standard Option** per urgent care center visit; a $40 copay under **High Option** and a $25 copay under **Standard Option** per emergency room visit for emergency care services which are covered benefits of this Plan. The emergency copayment is waived upon admission and:

High Option — **You pay** nothing

Standard Option — You pay a $200 copay per medical admission; a $400 copay per surgical admission.

What is covered

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

What is not covered

- Elective care or nonemergency care
- Emergency care provided outside the Service Area if the need for care could have been foreseen before departing the Service Area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the Service Area.

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 21.

Mental Conditions/Substance Abuse Benefits

Mental Conditions

What is covered

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

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

Outpatient care

All necessary outpatient visits to Plan doctors, consultants, or other Plan psychiatric personnel each calendar year; **you pay** 20% of charges per visit for visits 1 through 5; 35% of charges per visit for visits 6 through 30; and 50% of charges per visit for visit 31 and thereafter.

Inpatient care

All necessary inpatient care is covered. Under the High Option, **you pay** nothing. Under the Standard Option, **you pay** a $200 copay per admission.

What is not covered

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

Partial Hospitalization

Partial hospitalization is covered under **High Option** and **Standard Option** for up to 60 days per calendar year. **You pay** nothing. A partial hospitalization day is more than 4 hours, but less than 24 hours per day in a licensed or certified participating facility or program for intermediate, short-term or medically directed intensive treatment of alcohol abuse or mental illness. Partial hospitalization must meet all of the following conditions:

- The patient would require inpatient care if not admitted to this type of facility
- Short-term improvement can be expected
- The primary care doctor must authorize and the Plan must pre-approve the services.

Substance Abuse What is Covered

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

Prescription Drug Benefits

What is Covered

Prescription Drugs prescribed by a Plan or referral doctor will be dispensed by either a Plan pharmacy or through our Home Delivery Pharmacy Service for up to a 30-day supply for non-maintenance drugs and up to a 90 day supply for maintenance medication. A generic drug will be provided when substitution is permissible and a name brand is not specified by your doctor.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The Plan selects drugs for its formulary based upon quality and cost effectiveness, following review by its Pharmacy and Therapeutics Committee. The Plan has an "open formulary" which does not restrict a member's access to any FDA approved drug or change the copay, apart from savings to the member from using approved equivalent generic drugs. Nonformulary drugs are covered when prescribed by a Plan doctor.

Prescription Drug Benefits *continued*

Under **High Option** or **Standard Option**, **you pay** a $5 copay for up to a 30 day supply of generic drugs or a $10 copay for brand name drugs; under **Standard Option**, **you pay** the first $75 per person of covered benefits each calendar year. The deductible applies to prescriptions filled through a Plan pharmacy or the Home Delivery Pharmacy Service. For maintenance medication, **you pay** a $5 copay for a generic drug, or a $10 copay for a name brand drug for each 30 day supply or part of a 30 day supply of medication. Contact the Plan at (301) 441-1600 or (800) 635-3121 for information on filing claims and the Home Delivery Pharmacy Service.

Drugs for which a prescription is required by law are covered, including member health care costs for participating in clinical trials approved by the National Institutes of Health (NIH), a NIH cooperative group or center, the Food and Drug Administration (FDA), or the Department of Veteran Affairs for treatment of a life-threatening condition, and early detection and treatment of cancer. Experimental or investigational drugs or devices used are not covered; the investigational application of an FDA approved drug or device is covered. **You pay** the applicable copay and deductible, if appropriate.

In the case of a medical emergency outside of the Plan's service area when drugs are purchased from a non-participating provider, the Plan will provide reimbursement for up to a 10-day supply per prescription. **You pay** the applicable copay or drug deductible.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Contraceptive drugs and devices that require a prescription
- Insulin
- Disposable needles and syringes needed to inject covered prescribed medication, including insulin
- Intravenous fluids and medications for home use, when obtained through the Plan's home health service benefit
- Diabetic supplies (except that insulin pumps are covered under Medical and Surgical Benefits)

Limited benefits

Drugs to treat sexual dysfunction are covered. **You pay** a $15 copay and all charges thereafter under the **High Option**. **You pay** a $15 copay, any applicable deductible, and all charges thereafter under the **Standard Option**. Contact the plan for dose limits.

- Fertility drugs (oral and suppository only) are covered under the Plan's benefit for the treatment of infertility (described on page 13) at 50% of charges.

What is not covered

- Drugs available without a prescription or for which there is a non-prescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medications, including nicotine patches and nicotine gum
- Appetite suppressants
- Implanted time-release medications, except contraceptive drugs
- Injectables (except insulin and contraceptive drugs), aerosol inhalers and inhalant solutions except when obtained through the Home Delivery Pharmacy Service.
- Topical fluoride preparations

Other Benefits

Vision care - High Option only

What is covered

In addition to the Medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, the Plan covers the following vision care benefits when obtained from a Plan optometrist; eye refractions (eye examinations for eye glass prescription) eyeglasses and contact lens services, which include an eye exam and contact lens fitting, the actual lenses and follow-up care. Contact lens prescriptions are not dispensed separately. They are included in the contact lens service. **You pay** the copays listed below:

Benefit	You Pay	Benefit	You Pay
Exams and frames		**Lenses (per pair)**	
Eye examination	$25.00	Single vision	$20
Standard frames	$19.50	Bifocal	$40
Premium frames	$24.50	Trifocal	$50
Elite frames	$29.50	Lenticular	$72
		Progressive	$85

Contact lens services (per pair)
(Benefit includes examination, one (1) pair of contact lenses and follow-up care for three (3) months)

Benefit	You Pay	Benefit	You Pay
Standard lenses		**Replacement contact lenses (per pair)**	
Daily wear hard and soft	$90	**Standard lenses**	
Extended wear soft	$110	Daily wear hard and soft	$47
Gas permeable	$110	Extended wear soft	$72
Gas permeable extended wear	$120	Gas permeable	$72
Toric	$200	Gas permeable extended wear	$92
Premium lenses		Toric	$132
Daily wear hard and soft	$100	**Premium lenses**	
Extended wear soft	$120	Daily wear hard and soft	$62
Opaque soft extended wear lenses	$185	Extended wear soft	$101
Disposables (4) 6 packs per pair	$160	Opaque soft extended wear lenses	$126
		Disposables (4) 6 packs per pair	$86

Additional follow-up visits $15 per visit (after three (3) months)

What is not covered

- Eye exercises

Other Benefits *continued*

Dental care

What is covered

The following partial list summarizes the dental services provided by participating Plan dentists and indicates copays where they apply. Please check with the Plan for details. Unlisted procedures are provided at a 20% discount. All services are to be paid for at the time they are rendered.

Benefit	You Pay: Blue Plan (High Option)	Green Plan (Standard Option)
DIAGNOSTIC/PREVENTIVE*		
Comprehensive oral exam	Nothing	Nothing
Periodic oral exam	Nothing	Nothing
Limited oral examination - problem focused	$20	$30
Periodontal examination	Nothing	Nothing
Adult prophylaxis (routine cleaning, every six months)	$10	$20
Child prophylaxis - age 14 & under (routine cleaning every six months)	$10	$15
Topical application of fluoride	Nothing	Nothing
Radiographs		
- Periapicals x-ray-per film	$5	$6
- Bitewing x-ray - per film	$5	$6
- Complete series - including bitewings	$20	$30
- Panoramic x-ray	$20	$30
RESTORATIVE		
Amalgam Restorations (silver filing)		
- one surface	$28	$35
- two surfaces	$34	$45
- three or more surfaces	$40	$55
Resin Restorations (tooth colored filing)		
- one surface	$28	$45
- two surfaces	$34	$45
- three surfaces	$40	$65
- four or more surfaces or involving incisal angle	$80	$85
CROWN AND BRIDGE (per unit/tooth)		
Crown or pontic - porcelain - porcelain fused to metal	$295	$430
Crown or pontic - full cast metal	$285	$405
Porcelain laminate veneer	$275	$330
Crown buildup or post and core - in addition to crown	$90	$105
Stainless steel crown	$85	$95
Recement crown or bridge	$30	$30
a gold (high noble metal) surcharge may be assessed, not to exceed $50.00		
DENTURES		
Complete denture (upper or lower)	$355	$495
Partial denture, resin base (upper or lower)	$275	$325
Partial denture, metal framework with resin base (upper or lower)	$380	$560
Repair complete or partial denture base (in office)	$18	$35
Repair complete or partial denture base (laboratory)	$80	$80
Reline complete or partial denture base	$135	$180
Add or replace missing or broken tooth - first tooth (in office)	$18	$35
Add or replace missing or broken tooth - first tooth (laboratory) plus $10.00 for each additional tooth replaced	$90	$90
Repair partial cast framework	$80	$80
Add or repair or replace broken clasp - first clasp,	$90	$90.00 plus $35 for each additional clasp added
ENDODONTICS (excluding final restoration)		
Pulp cap - direct or indirect	$5	$10
Pulpotomy	$60	$60
Root Canal Therapy* -Anterior	$160	$225
- Bicuspid	$195	$290
- Molar	$265	$375
ADJUNCTIVE GENERAL SERVICES		
Local anesthesia	Nothing	Nothing
Analgesia (nitrous oxide) - per half hour	$15	$15
sealant - per tooth	$15	$15
Occlusal guard (night guard)*	$155	$190
OSHA compliance fee - per visit	Nothing	Nothing
Broken appointment fee (less than 24 hours notice) - per half hour	$15	$15

ENDODONTICS (excluding final restoration)		
Limited oral examination - problem focused**	$35	$35
Root Canal Therapy** - Anterior	$335	$335
- Bicuspid	$440	$440
- Molar	$520	$520
PERIODONTICS		
Comprehensive oral exam - consultation and treatment plan**	$90	$90
Limited oral examination - problem focused**	$35	$35
Full mouth debridement	$40	$40
Scaling and root planing - per quadrant	$95	$95
Periodontal maintenance (following active therapy)	$70	$70
Gingivectomy / gingivoplasty - per quadrant	$150	$150
Soft tissue graft procedure (including donor site)	$350	$350
Osseous surgery - or quadrant (including flap entry/closure)	$525	$525
Occlusal guard (night guard) **	$220	$220
16 oz Prescription PERIDEX (available at selected office only)	$19	$19
Nitrous oxide sedation (per 1/2 hour)	$15	$15
ORAL SURGERY		
Extraction - single tooth*	$25	$35
Limited oral examination - problem focused**	$35	$35
Panoramic x-ray**	$35	$35
Extraction - Single tooth	$42	$42
Surgical extraction of erupted tooth	$58	$58
Extraction of impacted tooth soft tissue	$78	$78
Extraction of impacted tooth - partial bony	$105	$105
Extraction of impacted tooth - full bony	$130	$130
Intravenous sedation or general anesthesia - per half hour	$80	$80
Patient will be liable for all hospital costs in the event dental treatment is provided in a hospital.		
ORTHODONTICS		
Initial Examination	Nothing	Nothing
Diagnostic Records and Consultation (including x-rays)	$120	$120
Comprehensive Orthodontic Treatment, Standard two year case for children under the age of 18	$2,040	$2,040

*Includes initial retainers and retention visits for six months *All standard orthodontic treatment cases that extend beyond two years are pro-rated at $85.00 per month. *Treatment or appliances necessary in addition to the standard two year case are provided at a 20% reduction of the Participating Dentist's customary fee. Non-standard orthodontic treatment (for children under age 18) is provided at a 20% reduction of the Participating Dentist's customary fee. Adult orthodontic treatment (for patients age 18 & over) is provided at a 20% reduction of the Participating Dentist's customary fee Appliance therapy for tooth guidance and space management is provided at a 20% reduction of the Participating Dentist's customary fee. Orthodontic treatment already in progress is not covered under the plan.

ADDITIONAL PROVISIONS

1. All member fees are to be paid directly to the Participating Dentist by the Member at the time treatment is provided.
2. Unlisted procedures are provided at a 20% reduction of the Participating Dentist's customary fee. This includes (but is not limited to) implant services and TMJ treatment.
3. Services provided by a Participating Pediatric dentist or Prosthodontist are covered at a 20% reduction of the customary fee.
4. Cosmetic Dentistry; There is no exclusion for necessary or appropriate treatment as performed for esthetic reasons.

*As performed by a NYLCare Participating General Dentist
**As performed by a NYLCare Participation Specialist

Non-FEHB Benefits Available to Plan Members

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

NYLCare HealthLine

NYLCare HealthLine is a health care decision counseling service that provides the information and support you need to help you get appropriate health care for yourself and your family. As a NYLCare member, you and your covered family members can dial 1-800-376-8936 from anywhere in the United States and Canada — 24 hours a day, seven days a week — to talk one-on-one with an experienced registered nurse.

NYLCare HealthLine is staffed by Express Scripts Inc., a nationally recognized leader in delivering health management services. The registered nurses at NYLCare HealthLine have a minimum of five years clinical experience as well as extensive training in telephone counseling techniques and services. Since time is critical, NYLCare HealthLine nurses have on-line access to medical protocols and medical journals.

NYLCare HealthLine is an innovative, proven information system that's designed to make your health and medical decisions less frightening and overwhelming. This program can help you understand your health care choices and communicate more effectively with health care providers.

Mothers To Be Program

The Mothers To Be Program provides prenatal care through enhanced monitoring and education, thus improving the chance that babies get a healthy start. The Mothers To Be Program is at no charge to you. This program includes:

A personal telephone interview with an experienced obstetrical nurse to review medical history and current status. Access to a 24 hour Pregnancy Hotline. Educational materials provided on a monthly basis during pregnancy. **An allowance towards Lamaze classes.** Contact Customer Service at (301) 441-1600 or (800) 635-3121 for more information.

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Services Office 24 hours per day, 365 days per year, at 301/441-1600, 800/635-3121, TDD 301/ 441-4535 or 800/522-7128 or you may write to the Plan at 7601 Ora Glen Drive, Greenbelt, MD 20770. You may also contact the Plan by fax at 301/489-5288; however, fax correspondence is best reserved for general comments not requiring a response, for routine questions or to request the "Information you have a right to know" referenced on page 6 of this brochure.

Disputed claims review

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure.

Plan reconsideration

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration, or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration, or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital. This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 4, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

How NYLCare Health Plans of the Mid-Atlantic Changes — January 1999

Program-Wide Changes:

Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.

- If you have a chronic, complex or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health Plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals. The length of time or number of visits from one referral varies depending on the condition and the needs of the member. See page 7 for further details.
- 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 (see pages 14 and 15).
- The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions benefits.

Changes to this Plan

- Under Prescription Drug Benefits, maintenance medication is now available at participatin pharmacies, as well as through Mail order, for up to a 90 day supply. A copay applies for each 30 day supply, or part of a 30 day supply of maintenance medication, whether the prescription is filled at a participating pharmacy or through the mail order service. Under Standard Option, a $75 deductible must now be met for prescriptions obtained at a participating pharmacy and/or by mail order service.
- Under Prescription Drug Benefits, the copay has changed to $5 for generic drugs and $10 for brand name drugs. These copays apply to prescriptions filled at a participating pharmacy or obtained by mail order service.
- Under Prescription Drug Benefits, coverage for diabetic equipment and supplies is expanded to include all necessary supplies. Items that require a prescription are subject to the prescription drug copays; insulin pumps are covered under Medical and Surgical Benefits without a copay.
- Coverage for drugs to treat sexual dysfunction is shown under Prescription Drug Benefits
- Prosthetic devices are covered, including artificial limbs, external lenses following cataract surgery and other permanent aids and supports.
- Under Mental Conditions/Substance Abuse Benefits, partial hospitalization for mental conditions and substance abuse is covered for up to 60 partial hospitalization days per calendar in a qualified participating facility.
- Short-term rehabilitative therapy now covers up to 60 visits per condition for physical therapy and up to 60 consecutive days per condition for other covered services.
- Coverage for treatment of cleft lip and cleft palate is expanded.
- Medical foods for the treatment of inherited metabolic diseases are covered.
- General anesthesia and related facility charges are covered for inpatient dental services for members who meet specified age, developmental, or emotional criteria.
- Coverage for home health services provided by skilled nurses and health aides is clarified to show you pay nothing under High Option or Standard Option.
- Under Other Benefits, the Dental care schedules for High Option and Standard Option are updated with different terminology. There are no changes in member copays or benefit levels, except that orthodontic benefits are clarified to show that all standard orthodontic treatment cases that extend beyond two years are pro-rated at $85 per month. Previously, this was incorrectly shown at $80 per month.

Summary of Benefits for NYLCare Health Plans of the Mid-Atlantic, Inc.- 1999

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated, subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure).

ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

Benefits		High Option pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing	11
	Extended Care	All necessary services, up to 60 days per member per year; **you pay** nothing	13
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions as needed. **You pay** nothing	16
	Substance Abuse	Covered under Mental conditions	16
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $5 copay per office visit or house call by a doctor (office visit copays are waived for care after the first maternity care visit)	13-14
	Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing	14
	Mental Conditions	All necessary outpatient visits per calendar year. **You pay** according to a sliding fee schedule	16
	Substance Abuse	Covered under Mental conditions	16
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $40 copay to the hospital for each emergency room visit and any charges for services that are not covered benefits of this Plan	14-15
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy or from the Home Delivery (Mail order) Pharmacy Service. **You pay** a $5 copay for generic drugs or a $10 copay for name brand drugs per 30 day supply; maintenance medication can be filled up to a 90 day supply either at a Plan pharmacy or through the Mail Order Service	16-17
Dental care		Full dental care; **you pay** copays for most services	19
Vision care		Comprehensive vision benefit. **You pay** a $25 copay per eye exam and various copays for lenses and frames	18
Out-of-pocket limit		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $650 per Self Only or $1,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include costs of dental services, prescription drugs, vision care, durable medical equipment, orthopedic devices, treatment of infertility, inpatient care of mental conditions/substance abuse, and vision care	8

Benefits		Standard Option pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** a $200 copay per medical admission; a $400 copay per surgical or maternity admission; a $50 copay per outpatient surgical visit	11
	Extended care	All necessary services, for up to 60 days per member per year; **you pay** nothing	13
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions as needed. You pay a $200 copay per admission	16
	Substance Abuse	Covered under Mental conditions	16
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per office visit or house call by a doctor (office visit copays are waived for care after the first maternity care visit)	13-14
	Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing	14
	Mental Conditions	All necessary outpatient visits per calendar year. **You pay** according to a sliding fee schedule	16
	Substance Abuse	Covered under Mental conditions	16
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $25 copay to the hospital for each emergency room visit and any charges for services that are not covered benefits of this Plan	14-15
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy or through the Home Delivery (Mail Order) Pharmacy Service. **You pay** a $5 copay for generic drugs or a $10 copay for name brand drugs per 30 day supply, after each member meets the annual $75 deductible; maintenance medication can be filled up to a 90 day supply either at a Plan pharmacy or through the Mail Order Service.	16-17
Dental care		Full dental care; **you pay** copays for most services	19
Vision care		No current benefit	
Out-of-pocket-limit		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,000 per Self Only or $2,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include costs of dental services, prescription drugs, durable medical equipment, orthopedic devices, and inpatient care of mental conditions/substance abuse	8

Notes

1999 Rate Information for

NYLCare Health Plans of the Mid-Atlantic

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

Postal rates apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		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
High Option Self Only	**JN1**	**$69.89**	**$23.29**	**$151.42**	**$50.47**	**$82.70**	**$10.48**
High Option Self and Family	**JN2**	**$160.39**	**$58.60**	**$347.51**	**$126.97**	**$183.29**	**$35.70**
Standard Option Self Only	**JN4**	**$49.39**	**$16.46**	**$107.01**	**$35.67**	**$58.44**	**$7.41**
Standard Option Self and Family	**JN5**	**$116.06**	**$38.69**	**$251.47**	**$83.82**	**$137.34**	**$17.41**