CIGNA HealthCare of Arizona, Inc. – Phoenix

2000

A Health Maintenance Organization

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

Serving: Phoenix area

Enrollment code:

161 Self Only
162 Self and Family

Service Area: You must live in the service area to enroll in this Plan.

Visit the OPM website at
http://www.opm.gov./insure
and
the Plan's website at
http://www.CIGNA.com/healthcare

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

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Introduction

CIGNA HealthCare of Arizona, Inc. – Phoenix
11001 North Black Canyon Highway, Suite 400
Phoenix, Arizona 85029

This brochure describes the benefits you can receive from CIGNA HealthCare of Arizona, Inc. – Phoenix under its contract (CS 1655) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 5. Premiums are listed at the end of this brochure.

Plain Language

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

We refer to CIGNA HealthCare of Arizona, Inc. – Phoenix as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

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

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

How To Use This Brochure

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

1. **Health Maintenance Organizations (HMOs).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. **How We Change For 2000.** If you are a current member and want to see how we have changed, read this section.

3. **How To Get Benefits.** Make sure you read this section; it tells you how to get services and how we operate.

4. **What To Do If We Deny Your Claim Or Request For Service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. **General Exclusions – Things We Don't Cover.** Look here to see benefits that we will not provide.

7. **Limitations – Rules That Affect Your Benefits.** This section describes limits that can affect your benefits.

8. **FEHB Facts.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

SECTION 1 — Health Maintenance Organizations

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

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

SECTION 2 — How We Change For 2000

Program-wide changes

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

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

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

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

If you are over age fifty (50), all FEHB Plans will cover a screening sigmoidoscopy every five (5) years. This screening is for colorectal cancer.

Changes to this Plan

Diabetic pharmaceutical supplies will now be covered under the Prescription Drug benefit. Medically necessary diabetic equipment will be covered under Medical Surgical Benefits *(See Durable Medical Equipment)*.

Prosthetic and orthopedic devices, which include artificial limbs and braces, are subject to an annual deductible of $200 and an annual maximum of $1000.

Dental care benefits are no longer offered.

Your share of the non-postal premium will increase by 13.6% for Self Only and decrease 0.6% for Self and Family.

SECTION 3 — How To Get Benefits

What is this Plan's service area?

To enroll with us, you must live in our service area. This is where our providers practice. Our service area is the Phoenix area.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services.

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

How much do I pay for services?

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

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

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

Do I have to submit claims?

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

Who provides my health care?

The Plan contracts with a group of doctors to provide your health care. You will select a primary care physician who supervises your total health care needs. A woman may see her Plan gynecologist for her annual routine examination without a referral.

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

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

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

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

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

First, call our Customer Service Department at 1-800-832-3211. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

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

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

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

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician in consultation with the Plan will use our criteria when creating your treatment plan.

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

Your primary care physician will decide what treatment you need. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

What do I do if my specialist leaves the Plan?

Call your primary care physician, who will arrange for you to see another specialist. You may call Customer Service in order to receive services from your current specialist until we can make arrangements for you to see someone else.

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

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

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

How do you authorize medical services?

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

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

The Plan evaluates new and emerging treatments (experimental or investigational treatments) on a case by case basis. The Plan uses a Medical Technology Assessment Council, peer-reviewed medical literature and independent medical experts to assist the Plan Medical Director in reaching determinations.

SECTION 4 — What To Do If We Deny Your Claim Or Request For Service

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

1. Be in writing;
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six (6) months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

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

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

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

When may I ask OPM to review a denial?

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

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

Call us at 1-800-832-3211 and we will expedite our review.

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

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

Are there other time limits?

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

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

What do I send to OPM?

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

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

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

Who can make the request?

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

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

What address should I send my disputed claim to?

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

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31st of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

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

Your records and the Privacy Act

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

SECTION 5 — Benefits

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; **you pay** a $10 office visit copay, $20 for after hour visits, but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if, in the judgement of the Plan doctor, such care is necessary and appropriate; **you pay** a $10 copay for a doctor's house call and nothing for home visits by nurses and health aides.

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

- Preventive care, including well-baby care and periodic check-ups.
- Mammograms are covered as follows: for women age 35 through 39, one (1) mammogram during these five (5) years; for women age 40 through 49, one (1) mammogram every two (2) years; for women age 50 through 64, one (1) mammogram every year; and for women age 65 and above, one (1) mammogram every two (2) 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. Copays are waived for maternity care. The mother, at her option, may remain in the hospital up to forty-eight (48) hours after a regular delivery, ninety-six (96) hours after a cesarean delivery. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services.
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum).
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, kidney and liver transplants; allogenic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplants are covered when approved by the Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Dialysis.
- Women who undergo a mastectomy may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to forty-eight (48) hours after the procedure.
- Chemotherapy, radiation therapy, and inhalation therapy.
- Surgical treatment of morbid obesity.
- Orthopedic devices, such as braces.
- Durable medical equipment, such as wheelchairs and hospital beds.
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.

Limited benefits

Oral and maxillofmacial 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. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

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

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for 60 consecutive days per condition if significant improvement can be expected within two (2) months; **you pay** $10 per outpatient session. 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.

Orthopedic and External Prosthetic devices, such as artificial limbs, are covered up to a $1,000 maximum Plan payment per calendar year, limited to the initial purchase and fitting unless replacement is due to normal anatomical growth. **You pay** the first $200 per calendar year and all charges after the Plan maximum annual benefit.

External lenses (intraocular and lenticular) following cataract surgery. **You pay** nothing.

Diagnosis and treatment of infertility is covered; **you pay** $20 per diagnostic visit. Intravaginal insemination (IVI) is covered; **you pay** $20; cost of donor sperm is not covered. Injectable fertility drugs are not covered under the Prescription Drug benefit. Injectable infertility drugs are covered as part of a Plan approved infertility treatment program under the Medical benefit. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization, intrauterine insemination (IUI) and embryo transfer and infertility drugs, are not covered.

Durable medical equipment, such as wheelchairs and hospital beds, is covered; **you pay** nothing per device.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel.
- Reversal of voluntary, surgically-induced sterility.
- Surgery primarily for cosmetic purposes.
- Homemaker services.
- Hearing aids.
- Transplants not listed as covered.
- Long-term rehabilitative therapy.
- Cardiac rehabilitation.
- Foot orthotics.
- Chiropractic services.
- Pulmonary rehabilitation.
- Shower chairs and commodes.

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** nothing. **All necessary services are covered,** including:

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

Extended care

The Plan provides a comprehensive range of benefits up to sixty (60) days per calendar 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 a hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. **You pay** nothing.

Limited benefits

Inpatient dental procedures

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

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 15 for non-medical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television.
- 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 forty-eight (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 forty-eight (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 a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

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

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

You pay . . . $50 per hospital emergency room visit or $20 per urgent care center visit in Plan facilities for emergency services that are covered benefits of this Plan. If emergency results in admission to a hospital, the copay is waived.

Emergencies outside the service area

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

If you need to be hospitalized, the Plan must be notified within forty-eight (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.

Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

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

You pay . . . $50 per hospital emergency room visit or $20 per urgent care center visit in Plan facilities for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the copay is waived.

What is covered

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

What is not covered

- Elective care or non emergency care.
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area.
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.

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 pages 8 and 9.

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 and chronic psychiatric conditions, including the treatment of mental illness or disorders:

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

Outpatient care

Up to thirty (30) outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; **you pay** a $5 copay per visit for sessions 1 through 20 and a $10 copay per visit for sessions 21 through 30 – all charges thereafter.

Inpatient care

Up to thirty (30) days of hospitalization each calendar year; **you pay** nothing for the first thirty (30) days – all charges thereafter. The benefits may be exchanged for partial hospitalization sessions of not less than three (3) hours and not more than twelve (12) hours in any twenty-four (24) hour period, based on the following exchange formula: If the charge for one partial hospitalization session does not exceed fifty percent (50%) of the published charges for one inpatient day of the average semi-private rate at the participating hospital where the session is conducted, the benefits exchange shall be two (2) partial hospitalization sessions equal to one day of inpatient care. If the charge for one partial hospitalization session does exceed fifty percent (50%) of the published charges for one inpatient day of the average semi-private rate at the participating hospital where the session is conducted, the benefits exchange shall be one partial hospitalization session equal to one day of inpatient care.

What is not covered

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

SUBSTANCE ABUSE

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care — All necessary visits to Plan providers for treatment; **you pay** a $5 copay for each covered visit.

Inpatient care — All necessary care in an alcohol detoxification or rehabilitation center approved by the Plan; **you pay** nothing.

What is not covered

- Treatment that is not authorized by a Plan doctor.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day or 100-unit supply, whichever is less; **you pay** a $5 copay for generic drugs or $10 for name brand drugs per prescription unit or refill. When generic substitution is possible (*i.e.*, a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, **you pay** the price difference between the generic and name brand drug as well as the $10 copay per prescription unit or refill.

You may also obtain Prescription drugs through the Home Delivery Pharmacy Service; **you pay** a $10 copay for up to a 90-day supply of generic drugs or $20 copay for name brand drugs when a generic drug is not permissible, with no annual deductible. When generic substitution is permissible (*i.e.*, a generic drug is available and the prescribing doctor does not require the use of a name brand drug) but you request the name brand drug, **you pay** the price difference between the generic and the name brand drug as well as the $20 copay per 90-day supply.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor and approved by the Plan's medical director. The Plan must arrange for the non-formulary drug to be dispensed when required to do so by the prescribing doctor.

The Plan's drug formulary is updated regularly by the Pharmacy and Therapeutics Committee. The Committee consists of providers, pharmacists, medical directors and pharmacy directors. They review medications for safety, therapeutic value and cost effectiveness. Based on this review, medications are added or deleted from the formulary.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law.
- Oral and injectable contraceptive drugs and contraceptive devices; contraceptive diaphragms.
- Implanted time release medications, such as Norplant; **you pay** a one-time copay of $10 for the office visit. There is no charge when the device is implanted during a covered hospitalization.
- Disposable needles and syringes needed for injecting covered prescribed medication, including insulin.
- Glucose test strips and lancets.
- Insulin.

Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits.

Limited benefit

Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. **You pay** a $10 copayment up to the dosage limits and all charges above that.

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.
- Drugs for cosmetic purposes.
- Smoking cessation drugs and medication, including nicotine patches.
- Drugs to enhance athletic performance.
- Vitamins and nutritional substances that can be purchased without a prescription.
- Medical supplies such as dressings and antiseptics.
- Infertility drugs.

Other Benefits

VISION CARE

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions, (which may include a lens prescription) may be obtained from Plan providers. **You pay** a $10 copay. Additionally, one pair single vision glass or plastic prescription lenses are provided each year; **you pay** a $10 copay.

What is not covered

- Replacements for any lenses provided during the same calendar year.
- Eye exercises.
- Frames.
- Contact lenses and their fitting.

Non-FEHB Benefits Available to Plan Members

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

Member Programs *
CIGNA HealthCare of Arizona
Greater Metro Phoenix

Alternative Care

We offer a variety of health education classes including Tai Chi. Additionally, through vendor arrangements, our members are entitled to discounts on vitamins and supplements as well as massage therapy.

Birthday Card Reminders

We understand that people are very busy and might forget important things like childhod immunizations and mammography screenings. So, we send reminders to all women and children on our Plan to make sure we see them for this and other preventive care.

Direct Access to OB/GYN

Women may choose to see a contracted OB/GYN for covered services without a referral from their PCP.

Guest Privileges

Eligible members can participate as a 'guest' through CIGNA's extensive national physician network when in another location for at least ninety days. *(For instance, a covered dependent student away at school.)* There are over fifty (50) networks nationwide!

- Temporary job assignments to another location.
- Family separations due to divorce.
- Children attending school away from home.

Healthy Babies Program

A program to encourage mothers to receive all routine prenatal care. Program includes high-risk assessment, access to health information line, no copayments for pre and postnatal visits, and lots of extras to help care for your new baby. Call our Baby Line at 602-553-2229 for more information.

24-Hour Health Information Line

We know that health issues don't care what time of day it is. That's why we offer our 24-hour health information line. Members in need of assistance can talk with one of our specially trained nurses; or select over 1200 topics on tape in our health information library. Call Member Services to receive a directory of topics.

Internet Access

The information you need – instantly, easily, and online. Our web site helps you find answers to your questions. You can search for participating providers, refill your Tel-Drug prescriptions, change your PCP, read online health and wellness publications, or send us an email. Visit our national web site at www.cigna.com/healthcare and explore to learn more.

Member Service Hours

We have extensive Member Service hours to serve you. A friendly representative is available to assist you from 7am to 9pm, Monday through Friday; 8am to 5pm on Saturday.

Wellness Classes

We offer classes for children, adults, and seniors. Instruction is provided by professionally trained educators on topics ranging from nutrition to stress management.

Well-Being

Stay current with your healthplan benefits and programs. We mail our members a health and wellness newsletter three times per year. *Well-Being* includes reminders about preventive care, quality programs, tips for using your health coverage and information on topics important to help you lead a healthy life.

** This program is provided for the benefit of CIGNA members and is not an endorsement of the services or vendors listed.*

Medicare prepaid plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 5, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-430-0768 for information on the Medicare prepaid plan and the cost of that enrollment.

SECTION 6 — General Exclusions – Things We Don't Cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition.

We do not cover the following:

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

SECTION 7 — Limitations – Rules That Affect Your Benefits

Medicare

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

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

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

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

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

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800-638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 17 .

Other group insurance coverage

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

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

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

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

Circumstances beyond our control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

TRICARE

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

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

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

Other Government Agencies

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

If you have a malpractice claim

If you have a malpractice claim because of services you did or did not receive from a plan provider, it must go to binding arbitration. Contact us about how to begin our binding arbitration process.

SECTION 8 — FEHB Facts

You have a right to information about your HMO.

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

If you want specific information about us, call 1-800-832-3211, or write to 11001 North Black Canyon Highway, Suite 400, Phoenix, Arizona 85029. You may also visit our website at www.cigna.com.

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

Your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans and other materials you need to make an informed decision about:

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

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

When are my benefits and premiums effective?

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

What happens when I retire?

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five (5) years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage, which is described later in this section.

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

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment thirty-one (31) days before and up to sixty (60) days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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

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

Are my medical and claims records confidential?

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

- OPM, this Plan, and subcontractors when they administer this contract;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

Information for new members

Identification cards

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

What if I paid a deductible under my old plan?

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

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan ends?

You will receive an additional thirty-one (31) days of coverage, for no additional premium, when:

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

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

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

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

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

Key points about TCC:

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

How do I enroll in TCC?

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

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

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

- Divorce
- Loss of spouse equity coverage within thirty-six (36) months after the divorce.

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

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

How can I convert to individual coverage?

You may convert to an individual policy if:

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

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

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

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

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

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

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-832-3211 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE – (202) 418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

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

Your agency may also take administrative action against you.

Summary of Benefits for CIGNA HealthCare of Arizona, Inc. – Phoenix / 2000

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

Benefits	Plan 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	12
Extended Care	All necessary services, for up to 60 days per year. **You pay** nothing	12
Mental Conditions	Diagnosis and treatment of acute and psychiatric conditions for up to 30 days of inpatient care per year. **You pay** nothing	14
Substance Abuse	All necessary care. **You pay** nothing	15
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; copays are waived for maternity visits after the first visit	14,15
Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing	10
Mental Conditions	Up to 30 visits per year. **You pay** a $5 copay per visit for visits one through 20 and a $10 copay per visits 21 through 30	14
Substance Abuse	All necessary care. **You pay** a $5 copay per visit	14
Emergency care	Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copay for each emergency room visit to non-Plan facilities and any charges for services that are not covered benefits of this Plan	13
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay for generic drugs or $10 for name brand drugs per prescription unit or refill	15
Dental care	Preventive dental care. Non-FEHBP benefits	16
Vision care	Annually, one refraction. **You pay** a $5 copay. One set of single vision lenses; **you pay** a $5 copay	16
Out-of-pocket maximum	Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments that are required for a few benefits	20

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

2000 Rate Information for CIGNA HealthCare of Arizona – Phoenix

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

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

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

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Phoenix Area									
Self Only	161	$ 75.98	$ 25.32	$164.61	$ 54.87	$ 89.90	$ 11.40	$ 89.90	$ 11.40
Self and Family	162	$175.97	$ 62.05	$381.27	$134.44	$207.74	$ 30.28	$201.02	$ 37.00