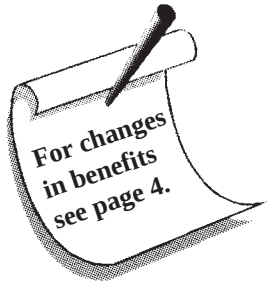
COMMUNITY HEALTH PLAN OF OHIO

Community Health Plan of Ohio

2000

A Health Maintenance Organization



Serving: Central/Southern/Southwestern/Southeastern/Northern Ohio

Enrollment in this Plan is limited; see page 5 for requirements.

Enrollment code:
MG 1 Self Only
MG 2 Self and Family

Visit the OPM website at http://www.opm.gov/insure

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Introduction

The Community Health Plan of Ohio (CHP of Ohio), 1915 Tamarack Road, Newark, Ohio 43055 has entered into a contract (CS2504) 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 CHPO or the Plan.

This brochure describes the benefits you can receive from Community Health Plan of Ohio under its contract (CS2504) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

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

Plain Language

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

We refer to Community Health Plan of Ohio 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 effect 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 (HMO).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

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

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

4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations.

6. **General exclusions — Things we don't cover.** Look here to see benefits that we will not provide.

7. **Limitations — Rules that effect your benefits.** This section describes limits that can affect your benefits.

8. **FEHB facts.** Read this 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 physician, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventive 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 physician, hospital, or other provider will be available and/ or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2 — How We Change For 2000

Program-wide changes

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

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

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

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

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

Changes to this Plan

Your share of the non-postal standard option premium will increase by 10.0% for Self Only or decrease 42% for Self and Family.

Inpatient Hospital care now requires a $50 copay per day up to a maximum $250 copay per admission.

Outpatient Surgery $50 copay per case.

Cardiac Rehabilitation $20 copay per visit.

Physical/Speech/Occupational Therapy $20 copay per visit for up to 90 treatments per contract year, combined.

Primary Care Physician (PCP) $10 copay per visit.

Specialty Care Physician (SPC) $20 copay per visit.

Non-Surgical Spinal Treatments are now covered at a $10 copay PCP/$20 copay SCP for up to 20 visits per contract year.

Mental Health Inpatient care now requires a $50 copay per day, up to $250 copay per admission.

Mental Health Outpatient $20 copay per visit.

Alcoholism & Substance Abuse Inpatient $50 copay per day maximum of $250 copay per admission.

Alcoholism & Substance Abuse Outpatient $20 copay per visit.

Ambulance $100 per trip.

Hospital Emergency Room $50 copay per visit.

Temporalmandibular Joint Dysfunction requires a 30% copayment.

Infertility Services now require a 30% copayment coverage includes testing and medical services, drugs excluded.

Out of Pocket Maximum per contract year are now reduced to $500 Single and $1,000 Family.

Mental Health, Alcoholism and Substance Abuse Copays do not apply toward the out of pocket maximum.

Decrease the Plan's service area by eliminating Butler and Hamilton counties.

Section 3 — How to get benefits

What is the Plan's service area?

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

Athens, Belmont, Brown, Clermont, Clinton, Coshocton, Delaware, Fairfield, Fayette, Franklin, Gallia, Greene, Guernsey, Harrison, Highland, Hocking, Holmes, Jackson, Knox, Lawrence, Licking, Marion, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Ottawa, Perry, Pickaway, Pike, Richland, Ross, Sandusky, Seneca, Scioto, Tuscarawas, Union, Vinton, Warren, Washington.

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.

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 a copayment (a set dollar amount) or coinsurance (a set purchase of charges). Please remember you must pay this amount when you receive services.

After you pay $500 in copayments or coinsurance for one family member, or $1,000 per 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, Mental Health, Alcoholism and Substance Abuse do not count toward these limits and you must continue to make these payments.

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you receive the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time. If you are required to pay for health care services, send itemized bills and proof of payment, within 60 days of performance of the services, or within 30 days of your receipt of billing, to Community Health Plan of Ohio, 1915 Tamarack Road, Newark, Ohio 43055.

Who provides health care?

Community Health Plan of Ohio (CHPO) is an IPA Model (Individual Practice Association) where patient care is obtained in the privacy of a doctor's office. When you enroll in CHPO, you will choose a local provider network for your entire family. A network is the participating providers in a specific local geographic area who have entered into agreements to provide health care services to plan enrollees. CHPO members must select a network for their entire family. All family members must select a primary care physician from the same network. All health services must be accessed from health care providers within the selected network, except for the treatment of medical emergencies. The services of providers outside the network are covered only when there has been a referral by the member's primary care doctor. There is no limit on the number of primary care doctors per family. There can be one for each family member, or you can all choose one doctor. The choice is yours. Primary care doctors are defined as doctors specializing in family practice, general practice, internal medicine, and pediatrics.

If members need to see a specialist, they will be referred by their primary care doctor. Members needing specialty care not provided in the network selected will be referred by their primary care doctor to the appropriate specialist outside the network at no additional cost to the member.

The primary hospital for scheduled inpatient admissions is the hospital associated with the network selected.

Role of 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 providers are covered only when you have been referred by your primary care doctor with the following exception: a woman may see her Plan obstetrician/gynecologist directly, with no need to be referred by her primary care doctor.

Choosing your doctor

The Plan's provider directory lists primary care doctors (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 on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at 740/348-1400; you can also find out if your doctor participates with this Plan by calling this number. 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 let the Plan know which primary care doctor(s) you've selected for you and each family member of your family by sending a selection form to the Plan. If you need help in choosing a doctor, call the Plan. 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.

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 to the hospital?

Talk to your Primary Care physician. If you need to be hospitalized, your primary care physician or authorized specialist will make the necessary hospital arrangements and supervise your care. All hospital services must be accessed from the hospital in the network you selected, except for treatment of emergencies. If you need hospital care not provided in the network selected, you will be referred by your primary care doctor to the appropriate hospital outside the network at no additional cost to you.

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

First, call our customer service department at 1-740-348-1400. 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, 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 except in a medical emergency. Referral to a participating specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals. When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the referral in advance. 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 before you may be hospitalized, referred for specialty care or obtain follow-up care from a specialist.

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

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 no participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

What do I do if my specialist leaves the Plan?

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

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

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause).

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

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice. If you seek the services of any Provider without Prior Authorization, you will be responsible for the cost of such services. Referral to a participating specialist is given at the discretion of your Primary Care Physician and The Plan and is not open ended. The referral will specify a number of visits and a time frame in which they may occur. A specialist may not refer to another specialist without the Prior Authorization of your Primary Care Physician and the Plan except for emergencies. All follow up care must be provided or authorized by your Primary Care Physician. If you go to the specialist for additional visits without obtaining Prior authorization from your Primary Care Physician and the Plan you will be responsible for the cost of such services.

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

The Plan uses peer-reviewed medical literature, FDA regulations, and review by any Institutional Review board to determine experimental, investigative, or unproved services such as medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies and devices.

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

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

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

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

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

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

When may I ask OPM to review a denial?

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

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

Call us (740-348-1400) and we will expedite our review.

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

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

Are there other time limits?

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

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.

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

What do I send to OPM?

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

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;

2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;

3. Copies of all letters you sent us about the claim

4. Copies of all letters we sent you about the claim; and

5. Your daytime phone number and the best time to call.

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

Who can make the request?

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

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

Where should I mail my disputed claim to OPM?

Send your request for review to : Office of Personnel Management, Office of Insurance Programs, Contract division IV, P.O. Box 436, Washington, 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 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a law suit?

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

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; 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 copayment to the Primary Care Physician and $20 copayment to the Specialist; you pay nothing for a doctor's house call or for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic checkups
- Annual preventive mammograms for women. In addition to routine screening, mammograms are covered when prescribed by a Plan doctor as medically necessary to treat or diagnose an illness
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, including laboratory tests and X-rays

Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. 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 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
- Diagnostic and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints. The cost of penile and scrotal implant devices is not covered.
- Cornea, heart, heart/lung, kidney, single lung, double lung, liver and pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need

- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you, except where noted

- Outpatient surgery provided with a copay of $50 per case.

Limited Benefits

Oral and maxillofacial surgery is provided for non-dental 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 treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

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

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an impatient or outpatient basis for up to 90 treatments per year combined per condition if significant improvement can be expected within two months; you pay $20 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.

Diagnosis and treatment of infertility, and the following types of artificial insemination are covered; intravaginal insemination (IVI) and intracervical insemination (ICI). You pay 30% of charges; cost of donor sperm is not covered. Other assisted reproductive techonology (ART) procedures, such as in-vitro fertilization and embryo transfer are not covered. Fertility drugs are not covered.

Durable Medical Equipment, such as wheelchairs and hospital beds, and prosthetic devices, such as artificial limbs, external lenses following cataract removal, pacemakers, breast prosthesis and surgical bras as well as their replacement are covered for the initial device only (unless required for life support), up to a lifetime maximum Plan payment per member of $5,000; you pay all charges thereafter. The Plan will cover replacements only when required due to growth from maturity.

Orthopedic supplies, including casts, splints, trusses, braces and crutches, and medical supplies, such as colostomy bags, are covered up to a maximum Plan payment of $500 per member per contract year; you pay all charges thereafter.

Cardiac Rehabilitation following a heart transplant, bypass surgery or myocardial infarction, is provided on an inpatient basis, including teaching, and on an outpatient basis, including exercise programs and cardiac monitoring. You pay $20 per visit. Outpatient exercise programs without cardiac monitoring are not covered.

Non-surgical Spinal Treatment

Coverage for non-surgical treatment limited to 20 visits per contract year with a copay of $10 if provided by the Primary Care Physician and $20 if provided by a Plan Specialty Care Physician.

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
- Transplants not listed as covered
- Hearing aids
- Long-term rehabilitative therapy
- Homemaker services
- Chiropractic services
- Foot orthotics
- Blood and blood derivatives not replaced by the member

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 $50 copay per day maximum $250 copay per admission. 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 for up to 60 days per contract 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 nurs ing facility when prescribed by a Plan doctor.

Hospice Care

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

Ambulance service

Transportation by professional ground ambulance or air ambulance when transportation is medically necessary. You pay $100 per trip.

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 procedures; the Plan will cover the hospitalization, but not the cost of professional dental services. Conditions for which hospitalization would not 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 14 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, blood and blood derivatives not replaced by the member.

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 should notify the Plan within 24 hours. 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 24 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.

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.

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

You pay . . . . . $50 per hospital emergency room visit or $30 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care 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 24 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 provider.

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

You pay . . . . . $50 per hospital emergency room visit or $30 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency visit results in admission to a hospital, the emergency care 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 doctor's services

Ambulance service by professional ground ambulance or air ambulance when medically necessary; you pay $100 per trip.

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 page 8.

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

Up to 30 outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; you pay a $20 copay for each covered visit-all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each contract year; you pay $50 copay per day/ maximum $250 copay per admission-all charges after 30 days.

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

Up to 30 outpatient visits to Plan providers for treatment each contract year; you pay a $20 copay for each covered visit-all charges after 30 visits.

The substance abuse benefit may be combined with the outpatient mental conditions benefit shown above, provided such treatment is necessary and is approved by the Plan, to permit an additional 30 outpatient visits per contract year with the applicable mental conditions benefit copayments.

Inpatient care

Up to 30 days per contract year in substance abuse rehabilitation (intermediate care) program in an alcohol detoxification or rehabilitation center approved by the plan; you pay $50 copay per day maximum $250 per admission.

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 supply or 100-unit supply, whichever is less; 240 milliliters of liquid (8oz.) 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (e.g. one inhaler, one vial ophthalmic medication or insulin). Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. The Plan uses a formulary that includes generic and preferred name brand drugs. Your doctor can ask for exceptions to the formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor. You pay a $5 copay per prescription unit or refill for generic drugs or for name brand drugs when generic substitution is not permissible. 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 name brand drug as well as the $5 copay per prescription unit or refill.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Oral and injectable contraceptive drugs
- Insulin, with a copay charge applied to each vial
- Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets
- Disposable needles and syringes needed to inject covered prescribed medication
- Intraveneous fluids and medications for home use

Limited Benefits

- Glucometers are covered for one per family per lifetime; you pay a 30% copay.
- Immunosuppressant drugs are covered ; you pay 50% of charges.
- Growth hormones are covered only for documented growth hormone deficiency in individuals under the age of 18; you pay 20% of charges

What is not covered

- Fertility drugs are not covered
- Drugs available without a prescription or for which there is a nonprescription 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

Drugs to aid in smoking cessation

Other Benefits

Dental Care

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury. You pay nothing.

What is not covered

- Other dental services not shown as covered

Vision Care

What is covered

In additional to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription) may be obtained from Plan providers. You pay a $20 copay per visit.

What is not covered

- Corrective lenses or frames
- Eye exercises

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 — Limitation - 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, please contact our office at 888-999-6608.

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 any 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 (OWPC) or a similar Federal or State agency determine they must provide; OWPC or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

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

Medicaid

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

Other Government Agencies

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

Section 8 — FEHB Facts

You have the right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which give 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 web site (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 740-348-1400 , or write to 1915 Tamarack Road, Newark, Oh 43055. You may also contact us by fax at 740-348-1500.

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

What happens when I retire?

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

What types of coverage are available for 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 22, including any foster or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who is incapable of self-support.

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

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

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

Are my medical and claims records confidential?

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

- OPM, this Plan, and subcontractors when they administer this contract,
- This plan, and appropriate third parties, such as other insurance plans and the
- Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims

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

Information for new members

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 the Plan ends?

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

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

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

What is former spouse coverage?

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

What is TCC?

Temporary Continuation of Coverage (TCC).

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

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

Key points about TCC:

You can pick a new plan;

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

How do I enroll in TCC?

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

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

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

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

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

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

How can I convert to individual coverage?

You may convert to an individual policy if:

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

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

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

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

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

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

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 740/348-1400 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 Community Health Plan of Ohio - 2000

The following benefits are available to Plan enrollees when provided, arranged or authorized by Plan Primary Care Physician. Covered health services must be Medically Necessary . 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 $50 per day, maximum $250 copay per admission.	12
	Extended Care	All necessary services, for up to 60 days per contract year. You pay nothing.	12
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay $50 copay per day maximum $250 per admission.	14
	Substance Abuse	Up to 30 days per year in a substance abuse treatment program. You pay $50 copay per day maximum $250 per admission.	14
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 $20 copay per office visit; nothing per house call by a doctor.	10
	Home Health Care	All necessary visits by nurses and health aides. You pay nothing.	10
	Mental Conditions	Up to 30 outpatient visits per year. You pay a $20 copay per visit.	14
	Substance Abuse	Up to 30 outpatient visits per year. You pay a $20 copay per visit.	14
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay a $50 copay to the hospital for each emergency room visit or $30 per urgent care center and any charges for services that are not covered by this Plan.	12, 13
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a $5 co-pay per prescription unit or refill	14, 15
Dental care		Accidental injury benefit; You pay nothing.	15
Vision care		One refraction annually. You pay a $20 copay per visit.	15
Out-of-pocket maximum		Co-payments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $500 for one family member or $1,000 per Family per contract year, covered benefits will be provided at 100%. This co-pay maximum does not include prescription drugs, Mental Health, and Substance Abuse.	5

2000 Rate Information for Community Health Plan of Ohio

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
Central/South/East									
Self Only	MG1	$65.37	$21.79	$141.64	$47.21	$77.35	$9.81	$77.35	$9.81
Self and Family	MG2	$139.10	$46.37	$301.39	$100.46	$164.60	$20.87	$164.60	$20.87