The Health Plan of the Upper Ohio Valley

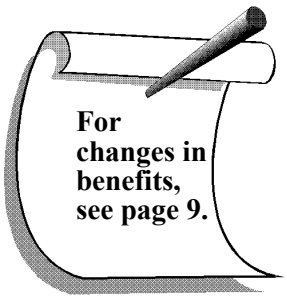
http://www.healthplan.org

2009

A Health Maintenance Organization (high option)

Serving: Northeast and Eastern Ohio, and Northern and Central West Virginia

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 6 for requirements.



This commercial HMO plan has an Excellent accreditation from the NCQA. See the 2009 Guide for more information on accreditation.

Enrollment code for this Plan:

U41 Self Only
U42 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

RI 73-553

Important Notice from The Health Plan About

Our Prescription Drug Coverage and Medicare

OPM has determined that The Health Plan's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and The Health Plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of The Health Plan HMO under our contract (CS 2616) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This plan is underwritten by The Health Plan. The addresses for the administrative offices are:

St. Clairsville, Ohio:

The Health Plan of the Upper Ohio Valley Inc. (The Health Plan HMO)
52160 National Road, East
St. Clairsville, Ohio 43950

Massillon, Ohio:

The Health Plan/HomeTown Regional Office
100 Lillian Gish Blvd.
P.O. Box 4816
Massillon, Ohio 44648

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means The Health Plan HMO.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider or authorized plan or OPM representative.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 our St. Clairsville office at 1-800-624-6961 or Massillon office at 1-800-426-9013 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety:

Ø www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of the most recent provider directory.

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital or other provider will be available and/or remain under contract with us.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. We pay our physicians under a fee-for-service basis, meaning that our physicians get paid only when they provide service to you.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

We are considered an Individual Practice Association (IPA) type of HMO, providing medical services by contracting with over 2,000 primary care and specialty care physicians and 40 hospitals. We serve the residents of Northeast Ohio, Eastern Ohio and Northern and Central West Virginia.

- We are a 501(c)(4) Not-for-Profit organization.
- We are federally qualified and state-certified.
- We hold Certificates of Authority in 21 West Virginia counties and 26 Ohio counties.
- We have excellent accreditation from the National Committee for Quality Assurance (NCQA).
- We began operations in 1979.

If you want more information about us, call 800-624-6961, or write to The Health Plan, 52160 National Road, East, St. Clairsville, Ohio, 43950. You may also contact us by fax at 740-695-5297 or visit our Web site at www.healthplan.org

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area encompasses these counties:

In Ohio: Ashland, Carroll, Columbiana, Coshocton, Cuyahoga, Geauga, Holmes, Knox, Lorain, Mahoning, Medina, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas, Wayne, Belmont, Guernsey, Harrison, Jefferson, Monroe, Muskingum, Noble and Washington.

In West Virginia: Barbour, Brooke, Doddridge, Gilmer, Hancock, Harrison, Lewis, Marion, Marshall, Monongalia, Ohio, Pleasants, Preston, Randolph, Ritchie, Taylor, Tucker, Tyler, Upshur, Wetzel, Wirt and Wood.

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 or urgent care. We will not pay for any other health care service outside our service area unless the services have prior plan approval.

If you or a covered family member moves outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if you 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 moves, you do not have to wait until Open Season to change plans. Contact your employment or retirement office.

Section 2. How we change for 2009

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to this Plan

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 60.
- There are no benefit changes for 2009.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us in the St. Clairsville office at 1-800-624-6961 or in the Massillon office at 1-800-426-9013, or write us at:

St. Clairsville Office:

The Health Plan of the Upper Ohio Valley Inc. (The Health Plan HMO)

52160 National Road East

St. Clairsville, Ohio 43950

Massillon Office:

The Health Plan/HomeTown Regional Office

100 Lillian Gish Blvd.

P.O. Box 4816

Massillon, Ohio 44648

You may also request replacement cards through our Web site at www.healthplan.org.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. If you use our Open Access program you can received covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site. We have three provider directories: one for the Ohio Valley Region, one for the Mountaineer Region and one for the HomeTown Region. The Ohio Valley Region directory includes providers in the northern panhandle of West Virginia and eastern Ohio; the Mountaineer Region directory includes providers in north and north central West Virginia; and the HomeTown Region directory includes providers in northeast Ohio.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician from our provider directory. This decision is important since your primary care physician provides or arranges for most of your health care. If you do not select a primary care physician, it may result in non-payment of claims.

- **Primary care**

Your primary care physician can be a family practitioner, general practitioner, general internal medicine, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one. You and each family member may change primary care physicians once per month.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see an OB/GYN without a referral if you select one as your secondary care physician.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex or serious medical condition, your primary care physician will work with us to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - Terminate our contract with your specialist for other than cause; or
  - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - Reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-624-6961 (St. Clairsville office) or 1-800-426-9013 (Massillon office). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this preauthorization. Your physician must obtain preauthorization for services such as, elective and extended hospital stays, CAT Scans, MRIs, outpatient surgeries, durable medical equipment, skilled nursing care, home health services, outpatient therapies, and scheduled ambulance transports.

We will review the requested service and our Medical Director will either approve it or deny it. In the event of denial, your physician will be notified by phone within one business day and by mail. You will receive notice by mail. If we do not authorize your services, you may request a second review. If we uphold our denial, you may file a formal appeal with us. See page 44 for the disputed claims process.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Copayments do not begin until you meet your deductible, unless there is no deductible for that service.

Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $250 per admission.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance does not count toward any deductible.

- The calendar year deductible is $250 per self-enrollment and $750 per family enrollment. Under a family enrollment, the deductible is satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $750.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance does not begin until you meet your deductible.

Example: You pay 20% of our allowable charges for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total $2,000 per self-enrollment or $6,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments/coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments/coinsurance for these services:

- Prescription drugs
- Dental services (accidental in nature)

Be sure to keep accurate records of your copayments/coinsurance since you are responsible for informing us when you reach the maximum. Your calendar year deductible does not count toward your catastrophic protection out-of-pocket maximum.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

Section 5. Benefits - OVERVIEW

See page 10 for how our benefits changed this year. Page 59 is a benefits summary. Make sure that you review the benefits available under the option in which you are enrolled.

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Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • In-office medical consultation • In-office surgical opinion • At home	$10 per visit to your primary care physician. $20 per visit to a specialist. (No Deductible)
• In an urgent care center (see page 35 for urgent care benefit) • During a hospital stay • In a skilled nursing facility • Second surgical opinion while in a hospital	Nothing
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	20% of our allowance.

Benefit Description	You pay After the calendar year deductible…
Preventive care, adult	**High Option**
Routine screenings, such as: • Total blood cholesterol • Colorectal cancer screening Routine Prostate Specific Antigen (PSA) test Routine Pap test Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five-year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC).	Nothing, if you receive these services during your office visit; otherwise, $10 per visit to your primary care physician; $20 per visit to a specialist. (No Deductible)
Not covered: Physical exams and immunizations not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing, if you receive these services during your office visit; otherwise, $10 per visit to your primary care physician; $20 per visit to a specialist. (No Deductible)
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	$10 per visit to your primary care physician. $20 per visit to a specialist. (No Deductible)
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Here are some things to keep in mind:	$20 for initial office visit only. (No Deductible)

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible…
Maternity care (cont.)	**High Option**
• You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a Cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$20 for initial office visit only. (No Deductible)
Not covered:Routine sonograms to determine fetal age, size or sex.	*All charges*
Family planning	**High Option**
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo Provera) • Contraceptive devices, such as diaphragms and intrauterine devices (IUDs) Note: We cover oral contraceptives under the prescription drug benefit.	$10 per visit to your primary care physician; $20 per visit to a specialist. Note: The copay for injectable contraceptive drugs (i.e., Depo Provera) and contraceptive devices (i.e., IUD/diaphragms) is 30% of our allowance, in addition to the office visit copay.
Not covered: reversal of voluntary surgical sterilization, genetic counseling, paternity testing, Estrogen & Androgen pellet implants.	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI)	30% of our allowance.

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**High Option**
• Basic healthcare services such as diagnostic and exploratory procedures to determine infertility including surgical procedures to correct medically diagnosed diseases or conditions of the reproductive organs	30% of our allowance.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* *- in vitro fertilization* *- embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* *- surrogate parenting* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs (oral, topical or injectible)* • *Experimental services*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	$10 per visit to your primary care physician. $20 per visit to a specialist.
Allergy serum	Nothing (No Deductible)
Not covered: sublingual allergy desensitization	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27.	20% of our allowance.
Respiratory and inhalation therapy Dialysis – hemodialysis and peritoneal dialysis Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	$10 per visit to your primary care physician. $20 per visit to a specialist.
Biotechnology Agents, such as Growth Hormone Therapy (GHT) and Betaseron	30% of our allowance.

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	**High Option**
Note: We cover GHT under our medical benefits only when we preauthorize the treatment. For preauthorization, call 1-800-624-6961 (St. Clairsville office) or 1-800-426-9013 (Massillon office). We will ask you to submit information that establishes the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	30% of our allowance.
Physical and occupational therapies	**High Option**
Outpatient (the greater of two months or 20 visits per condition) and inpatient (60 days per calendar year) for the services of each of the following: • qualified physical therapists and • occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	$10 per office visit. $20 per outpatient visit. Nothing per visit during covered inpatient admission.
• Cardiac rehabilitation at a plan-approved facility for up to 12 weeks or 36 visits per heart attack or heart surgery.	$10 per outpatient visit.
• Pulmonary rehabilitation at a plan-approved facility for up to 12 weeks or 36 visits per calendar year.	$10 per outpatient visit.
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**High Option**
Outpatient (the greater of two months or 20 visits per condition) and inpatient (60 days per calendar year)	$20 per outpatient visit. Nothing per inpatient visit.
Hearing services (testing, treatment and supplies)	**High Option**
• Hearing exams are limited to one per calendar year to determine the need for hearing correction • Hearing testing for children through age 17 (see *Preventive care, children)* • Hearing aids are limited to one hearing aid per lifetime	$10 per visit to your primary care physician. $20 per visit to a specialist. (No Deductible) Note: You pay 30% of our allowance for hearing aids.

Hearing services (testing, treatment and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Hearing services (testing, treatment and supplies) (cont.)	**High Option**
Not covered: • *All other hearing testing* • *Replacement or repair of hearing aids and batteries for them*	*All charges*
Vision services (testing, treatment and supplies)	**High Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam provided by PCP, to determine the need for vision correction for children through age 17 (see preventive care) • Ophthalmologist visits for diagnosis and treatment of diseases of the eye (requires prior approval)	$10 per visit to your primary care physician. $20 per visit to a specialist.
Not covered: • *Eyeglasses, frames or contact lenses and examinations for them, after age 17* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$20 per office visit. (No Deductible)
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of fallen arches, weak, strained or flat feet or bunions or spurs, and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Strapping or taping of the feet* • *Hygienic and preventive maintenance care such as, cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients and any other service performed in the absence of localized illness, injury or symptoms involving the foot*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Foot orthotics • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	30% of our allowance.
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose and other supportive devices* • *Replacement of prosthetics provided prior to the end of their expected life (except for replacement due to growth or development in children up to age 18)*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Hospital beds • Standard model wheelchairs • Crutches • Walkers • Ostomy and catheter supplies • Insulin pumps Note: DME must be medically necessary and be pre-authorized by us prior to dispensing. DME is limited to standard model only.	30% of our allowance.
• Blood glucose monitors Note: We require the use of specific blood glucose monitors.	Nothing

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	**High Option**
Not covered: • *Replacement of DME prior to the end of its expected life (except for replacement due to growth or development in children up to age 18)* • *Batteries for DME items, such as hearing aids, tens units, wheelchairs and glucometers* • *Equipment or supplies primarily used for patient comfort or convenience* • *Home modifications* • *Supplies such as tape, alcohol, cotton swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags* • *Professional medical equipment such as blood pressure units or stethoscopes*	*All charges*
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. Note: We must preauthorize Home health services prior to services being rendered.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.*	*All charges*
Chiropractic	**High Option**
• Up to 20 visits per calendar year with approved referral from your PCP	$20 per office visit. (No Deductible)
Not covered: • *Non-subluxation services*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Alternative treatments	**High Option**
Biofeedback Therapy (for incontinence only)	30% of our allowance.
Not covered: • *Acupuncture services* • *Naturopathic services* • *Hypnotherapy* • *Biofeedback (except for incontinence)* • *Massage therapy* • *Christian Science Treatment* • *All other alternative treatment services not listed as covered*	*All charges*
Educational classes and programs	**High Option**
Coverage is limited to: • Work Site Smoking Cessation classes – This program is available when requested by your employer and is provided by our nurse educator. If you are interested in these classes, please call us at 800-624-6961 or 740-695-3585 for more information. *{See http://www.surgeongeneral.gov/tobacco for more info.}* • Diabetes education – Up to eight group and eight individual classes in a 12-month period.	Nothing

Section 5(b). Surgical and anesthesia services provided by physicians and other healthcare professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to almost all benefits in this section. We added "(No Deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other healthcare professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) -- a condition in which an individual weighs 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information.	$10 per visit to your primary care physician. $20 per visit to a specialist. Nothing for hospital visits. **Note: These 5 criteria must be met for The Health Plan's approval of bariatric surgery:1)**Extreme obesity; **2)** Medically appropriate for the individual to have surgery; **3)** Surgery is to correct illness, which caused the obesity or was aggravated by the obesity; **4)** Complete medical history and clinical support to cover procedure; **5)** Follow medical guidelines for the coverage.
• Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**High Option**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: • - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; webbed fingers and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Treatment for temporomandibular (TMJ) disorders (non-dental)	$10 per visit to your primary care physician. $20 per visit to a specialist. Nothing for hospital visits.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)* • *Non-medical TMJ services*	*All charges*
Organ/tissue transplants	**High Option**
Solid organ transplants are subject to medical necessity and experimental/investigative review. Review to *Other services* in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description. • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Bowel transplant • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (LL/SLL). - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)	Nothing
Blood or marrow stem cell transplants for: · Allogeneic transplants for: - Advanced forms of myelodysplastic syndromes - Infantile malignant osteopetrosis - Kostmann's syndrome - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome · Autologous transplants for: - Multiple myeloma	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer	Nothing
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for. · Allogenic transplants for: - Multiple myeloma · Nonmyeloblative allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Multiple myeloma · National Transplant Program (NTP) Note: We cover actual acquisition costs of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Anesthesia	**High Option**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Skilled nursing facility	Nothing
Professional services provided in: • Office	$10 per visit to your primary care physician. $20 per visit to a specialist.

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to almost all benefits in this section. We added "(No Deductible)" to show when the calendar year does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge(i. e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR ELECTIVE HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: The calendar year deductible applies only when we say below: "(calendar year deductible applies)".	
Inpatient hospital	**High Option**
Room and board, such as: • Ward, semi-private, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semi-private room rate.	$250 per admission.
Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	$250 per admission.
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Non-covered facilities* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma and other biologicals • Blood and blood plasma • Dressings, casts and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
• Diagnostic laboratory tests, X-rays and pathology services • Pre-surgical testing	20% of our allowance.
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Skilled nursing facility (SNF): Up to 120 days per calendar year when full-time nursing care and confinement to an SNF is medically appropriate. All necessary services are covered, such as: • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the SNF when prescribed by your physician	$35 per day.
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Non-covered facilities*	*All charges*

Benefit Description	You pay
Hospice care	**High Option**
• Supportive and palliative care for a terminally ill member, including home care and family counseling Note: These services are provided when your physician certifies that the member is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: • *Independent nursing, homemaker services* • *See "not covered" under SNF benefits Private nursing care*	*All charges*
Ambulance	**High Option**
• Local professional ambulance service when medically appropriate	$50 per service.

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year deductible does not apply

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency?

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

What to do in case of emergency:

In extreme emergencies, contact the local emergency system (i.e., 9-1-1 telephone system). If you are in an emergency situation, you should follow these steps:

- **First:** When practical, call your primary care physician - day or night. He or she can direct you to the appropriate care and can assure the proper follow-up to that care.
- **If your primary care physician cannot be reached**, call our 24-hour emergency number, 1-800-624-6961 (St. Clairsville office) or 1-800-426-9013 (Massillon office). You will be put in contact with our nurse on call and receive directions on what to do.
- **In a situation when a telephone call is impractical or impossible**, go directly to one of our nearest participating hospital emergency rooms, if possible. Identify yourself as a Health Plan member. You or a family member must contact us within 48 hours of the visit, unless it was not reasonably possible to do so. It is your responsibility to ensure that we have been notified in a timely manner. You should also inform your physician of the situation so that he/she may properly coordinate your care.

Emergencies within our service area: If you are in an emergency situation within our service area, please follow the above steps under "What to do in case of emergency." If you need to be hospitalized, we must be notified within 48 hours or on the first working day following the admission, unless it was not reasonably possible to notify us within that timeframe. If you are hospitalized in a non-Plan facility and your physician believes care can be better provided in a Plan facility, 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. Any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers.

Emergencies outside our service area: If you are in an emergency situation outside our service area, please follow the above steps under "What to do in case of emergency." If you need to be hospitalized, we must be notified within 48 hours or on the first working day following the admission, unless it was not reasonably possible to notify us within that timeframe. If your physician 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 us or provided by Plan providers.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	**High Option**
Emergency care at a doctor's office	$10 per visit to your primary care physician. $20 per visit to a specialist. (No Deductible)
Emergency care at an urgent care center	$50 per visit. (No Deductible)
Emergency care as an outpatient at a hospital, including doctors' services	$75 per visit. (No Deductible) Note: Waived if admitted, see Inpatient benefit.
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**High Option**
Emergency care at a doctor's office	$10 per visit to a primary care physician. $20 per visit to a specialist. (No Deductible)
Emergency care at an urgent care center	$50 per visit. (No Deductible)
Emergency care as an outpatient at a hospital, including doctors' services	$75 per visit. (No Deductible) Note: Waived if admitted, see Inpatient benefit.
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**High Option**
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	$50 per service.

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

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Mental health and substance abuse benefits	**High Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists or clinical social workers • Medication management	$20 per visit. (No Deductible)
• Diagnostic tests	Nothing, if you receive these services during your office visit; otherwise, $10 per visit.
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility-based intensive outpatient treatment	$250 per admission.
Not covered: Services we have not approved.	*All charges*

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
Mental health and substance abuse benefits (cont.)	**High Option**
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	*All charges*

Preauthorization	To be eligible to receive these benefits, you must obtain a treatment plan and follow the network authorization process: Contact our Behavioral Health Administrator toll free at 1-877-221-9295 for mental health and substance abuse services.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible on prescription drugs.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription?** A licensed physician must write the prescription – or – a plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy or by mail order.
- **We use a formulary.** Drugs are prescribed and dispensed in accordance with our drug formulary. A drug formulary is a list of brand-name drugs that we cover. The formulary is reviewed and updated, and is subject to change. We cover non-formulary drugs prescribed by a Plan doctor. If your physician believes a name-brand product is necessary or there is no generic available, your physician may prescribe a name-brand drug from our formulary list. This list of name-brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To request a prescription drug brochure or formulary, call 1-800-624-6961 (St. Clairsville office) or 1-800-426-9013 (Massillon office). You may also choose to receive a non-formulary prescription and pay the higher third-tier copay.
- **There are dispensing limitations.** Generally, we allow dispensing of FDA-approved drugs up to a 31-day supply per copay. Limits may be applied to assure that dispensing of medication conforms to the approved federal labeling of the formulary drug. Furthermore, if you have your prescription filled too early, it will not be allowed. You must use three-fourths of the days supplied before a refill will be allowed.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs. You and your physician have the option to request a name-brand even if a generic is available. However, using the most cost-effective medication saves money.

- **When you have to file a claim.** If you are in a situation outside our service area for which you cannot go to a plan pharmacy, and a physician has prescribed covered medication that is urgently needed, please go to any pharmacy and purchase the medication. Return your receipt to The Health Plan and you will be reimbursed in full, less the applicable copay amount.
- **In cases of active military duty (or in time of national emergency).** Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Member Services Department at 1-800-624-6961 (St. Clairsville office) or 1-800-426-9013 (Massillon office).

Benefit Description	You pay
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	**High Option**
We cover the following medications and supplies when prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal Law of the United States require a physician's prescription for their purchase, except those listed as "Not covered." • Diabetic supplies, including insulin, glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets • Disposable needles and syringes for the administration of covered medications • Intravenous fluids and medications for home use; some injectible drugs (such as Depo Provera) are covered under medical services and supplies • Contraceptive drugs and devices (devices are covered under medical services and supplies) • Prenatal vitamins • Sexual dysfunction drugs have dispensing limitations. Contact the Plan for details.	**Retail Pharmacy (up to a 31-day supply):** $15 per prescription unit or refill for generic drugs. $30 per prescription unit or refill for formulary brand-name drugs. $50 per prescription unit or refill for non-formulary brand-name drugs. **Home Delivery Mail Order Pharmacy (up to a 90-day supply for maintenance medications):** $30 per prescription unit or refill for generic drugs. $60 per prescription unit or refill for formulary brand-name drugs. $100 per prescription unit or refill for non-formulary brand-name drugs.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medications, including nicotine patches* • *Drugs for weight control* • *Fertility drugs* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Nonprescription medicines*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- We cover hospitalization days for oral surgical procedures only when certified by the primary care physician as being medically necessary to safeguard your life and approved by us. See Section 5(c) for inpatient hospital benefits. We do not cover dental procedures.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Services have to be initiated and rendered within six months of the accident.	Nothing
Dental benefits	**High Option**
We have no other dental benefits.	

We have no other contractual dental benefits. See Non-FEHB benefits available to Plan members on the next page.

Section 5(h). 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 who are members of this Plan**. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductible, catastrophic protection out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims procedures.

Medicare Advantage Plan: This Plan offers Medicare recipients the opportunity to enroll in one of its Medicare Advantage plans: SecureCare HMO, SecureChoice PPO or SecureFreedom PFFS. Our service area for Medicare Advantage is different then our FEHB program service area. You must have Medicare parts A & B to enroll in a Medicare Advantage plan. For more information, please contact us at 1-877-847-7915/TTY 1-800-622-3925 (St. Clairsville office) or 1-877-236-2290/TTY 1-877-236-2291 (Massillon office), Monday through Friday, 8:30 a.m. to 5 p.m.

Vision One Eyecare Program: The Plan is pleased to offer our FEHB members savings on your eyecare needs... frames, lenses, contacts and exams. Operated in conjunction with EyeMed Vision Care, you may obtain substantial savings on a wide range of vision services at any of the 1600 participating eyecare centers at Sears, JC Penny, Pearle Vision Express Departments nationwide, as well as many private practitioners. To take advantage of these savings, simply show your Health Plan ID card at participating eyecare centers. Your savings are applied directly to your purchase. There is no paperwork to fill out or claim forms to submit.

Dental Benefit: The Plan provides dental coverage under DeltaPreferred Option USA (DPO USA), a national point-of-service preferred provider organization administered by Delta Dental. You may go to any licensed dentist, but you may lower your out-of-pocket costs by going to a DPO dentist. If you do not go to a DPO dentist, you will be covered by DeltaPremier USA, Delta Dental's carefully managed fee-for-service program. However, you might have to pay more. For more information on this **free benefit**, please contact us at 1-800-624-6961 (St. Clairsville office) or 1-800-426-9013 (Massillon office).

Delta Dental Plan of Ohio	
Diagnostic and Preventive Service	**High Option**
Used to diagnose and/or prevent dental abnormalities or disease. Includes: • Two cleanings per calendar year • Two exams per calendar year	80%
Emergency Palliative Treatment	**High Option**
Used to temporarily relieve pain	80%
Radiographs	**High Option**
X-rays as required for routine care or as necessary for the diagnosis of a specific condition. Includes: • One set of bitewing X-rays per calendar year • One set of full mouth X-rays per every five years	80%

The Health Plan Customer Service toll-free numbers:

1-800-624-6961 (St. Clairsville office) or 1-800-426-9013 (Massillon office)

www.healthplan.org

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness, disease, injury or condition and we agree, as discussed under Services Requiring Our Prior Approval on page 13.**

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);
- Services, drugs or supplies you receive while you are not enrolled in this Plan;
- Services, drugs or supplies not medically necessary;
- Services, drugs or supplies not required according to accepted standards of medical, dental or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs or supplies related to sex transformations;
- Services, drugs or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits; other supplies or services

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500 (Health Insurance Claim Form). Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-624-6961 (St. Clairsville office) or 1-800-426-9013 (Massillon office).

When you must file a claim – such as for services you receive outside the Plan's service area – submit it on the HCFA-1500 or a claim form that includes the information listed below. Bills and receipts should be itemized and show:

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

Submit your claims to the St. Clairsville Office:

The Health Plan

Attn: Claims Department

52160 National Road, East

St. Clairsville, Ohio 43950

Or to the Massillon Office:

The Health Plan/HomeTown Regional Office

Attn: Claims Department

100 Lillian Gish Blvd

P.O. Box 4816

Massillon, Ohio 44648

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs or supplies – including a request for preauthorization/prior approval required by Section 3.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within six months from the date of our decision; and b) Send your request to The Health Plan at our St. Clairsville Office: 52160 National Road East, St. Clairsville, Ohio 43950 or our Massillon Office: 100 Lillian Gish Blvd., P.O. Box 4816, Massillon, Ohio 44648; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the healthcare provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

The disputed claims process*(continued)*

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

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

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

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

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

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

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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-624-6961 (St. Clairsville office) or 1-800-426-9013 (Massillon office) and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You may call OPM's Health Insurance Group 3 at 1-202-606-0737 between 8 a.m. and 5 p.m., Eastern Time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits three months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. To find out if you need to do something about filing your claim, call us at 1-800-624-6961 (St. Clairsville office) or 1-800-426-9013 (Massillon office), or email us at info@healthplan.org.

We do not waive any costs if the Original Medicare plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan, called SecureCare, and also remain enrolled in our FEHB plan. In this case, no copayments or coinsurance are waived for your FEHB coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.
- Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for injuries or illness for which another party may be responsible, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

The words "Third Party," "Any Party" or "Responsible Party" includes not only the insurance carrier(s) for the responsible party, but also any uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage or any other first party insurance coverage. The words "Member," "you" and "your" include anyone on whose behalf the Plan pays or provides any benefits.

If you do not seek damages, you must agree to let us try. This is called subrogation.

You specifically acknowledge our right of subrogation. When we provide health care benefits for injuries or illnesses for which another responsible party is or may be responsible, we shall be subrogated to your rights of recovery against any responsible party to the extent of the full cost of all benefits provided by us, to the fullest extent permitted by law. We may proceed against any responsible party with or without your consent.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket costs.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 14.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Treatment or services that are designed mainly to help the patient with daily living activities.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 14.
Experimental or investigational services	Services, devices or drugs that we determine are not nationally accepted in conjunction with accredited specialty consultants, government agencies and other regulatory agencies.
Group health coverage	Healthcare coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical or other healthcare services or supplies.
Medical necessity	A service, device or drug that meets its standardized medical criteria, derived from recognized accredited national sources. It is important to know that your physician may recommend a service, device or drug that may sometimes not qualify as being medically necessary. Medical necessity is determined by our medical staff, in coordination with local or regional members of the medical community or academic faculties.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance based on our contracted amounts with our providers.
Us/We	Us and We refer to The Health Plan HMO.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

Types of coverage available for you and your family

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

If you have a Self-Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before, to 60 days after, that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self-Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self-Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2008 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2007 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31st day temporary extension.

Upon divorce

If you are divorced from a federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

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 Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

You may convert to a non-FEHB individual policy if:

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

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that offers limited federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about federal and state agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage, or any other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses for your child(ren) under age 13 or for dependents unable to care for themselves that allow you (and your spouse, if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM Web site at www.opm.gov/insure/dentalvision. This site also provides links to each plan's Web site, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Do not rely completely on the page listings in this index; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for The Health Plan HMO - 2009

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the calendar year deductible.

Benefits	You pay	Page
Medical services provided by physicians*:		16
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $20 specialist.	16
Services provided by a hospital*:		31
• Inpatient	$250 per admission.	31
• Outpatient	Nothing.	32
Emergency benefits:		34
• In-area	$75 per visit.	35
• Out-of-area	$75 per visit.	35
Mental health and substance abuse treatment*:	Regular cost sharing.	36
Prescription drugs:		38
• Retail pharmacy	Retail (31-day supply) $15 copay generic $30 copay formulary brand $50 non-formulary brand	39
• Mail order	Mail Order (90-day supply) $30 copay generic $60 copay formulary brand $100 non-formulary brand	39
Dental care:	No contractual benefit. See Non-FEHB page for **free** dental coverage.	40 41
Vision care*:	$10 primary care; $20 specialist.	41
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)**:**	Nothing after $2,000/Self-Only or $6,000/Family enrollment per year. Some costs do not count toward this protection.	14

2009 Rate Information for The Health Plan of the Upper Ohio Valley

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

Postal rates apply to career Postal Service employees. Most employees should refer to the Guide to Benefits *for Career* United States Postal Service Employees, RI 70-2, and to the rates shown below.

The rates show below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Northeast and Eastern Ohio							
High Option Self Only	U41	144.86	48.29	313.87	104.62	167.07	26.08
High Option Self and Family	U42	333.18	111.06	721.89	240.63	384.27	59.97
Northern and Central West Virginia							
High Option Self Only	U41	144.86	48.29	313.87	104.62	167.07	26.08
High Option Self and Family	U42	333.18	111.06	721.89	240.63	384.27	59.97