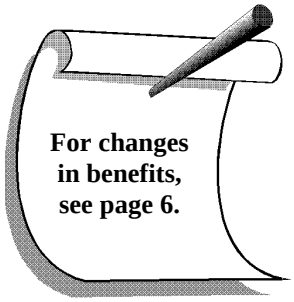
Mail Handlers Benefit Plan

http://www.mhbp.com/

2002

A fee-for-service plan with a preferred provider organization

Sponsored by: the National Postal Mail Handlers Union, a Division of LIUNA, AFL-CIO.



Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program and who are, or become, members or associate members of the National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO.

To become a member or associate member: If you are a non-postal employee/annuitant, you will automatically become an associate member of the National Postal Mail Handlers Union upon enrollment in the Mail Handlers Benefit Plan. There is no membership charge for members of the National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO.

Membership dues: $42 per year for an associate membership. New associate members will be billed by the Mail Handlers Union for annual dues when the Plan receives notice of enrollment. Continuing associate members will be billed by the Mail Handlers Union for the annual membership.

Enrollment codes for this Plan:

451 High Option - Self Only
452 High Option - Self and Family
454 Standard Option - Self Only
455 Standard Option - Self and Family

Authorized for distribution by the:
UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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FEHB
Federal Employees
Health Benefits Program

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Introduction

Mail Handlers Benefit Plan
P.O. Box 45118
Jacksonville, Florida 32232-5118

This brochure describes the benefits of the Mail Handlers Benefit Plan. The National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO has entered into a contract (CS1146) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefit law. This Plan is underwritten by Niagara Fire Insurance Company, a CNA company. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means the Mail Handlers Benefit Plan
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the 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 Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-410-7778 and explain the situation.
- If we do not resolve the issue, call or write:

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

Penalties for fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they try to obtain services for a person who is not an eligible family member, or are no longer enrolled in the Plan and try to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this fee-for-service plan

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

Preferred Provider Organizations (PPO)

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. Contact us for the names of PPO providers. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Continued participation of any specific provider cannot be guaranteed. When you phone for an appointment, please remember to verify that the health care professional or facility is still a PPO provider. Do not call OPM or your agency for our provider directory.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. If you receive non-covered services from a PPO provider, the PPO discount will not apply and these services will be excluded from coverage.

When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.

Managed Network Providers

This Plan has a contract with United Behavioral Health to administer our mental conditions/substance abuse benefits. They have contracts with mental health professionals to provide these services. See Section 5(e) page 46.

MultiPlan Participating Providers

This Plan has a contract with MultiPlan. MultiPlan has entered into contracts with non-PPO providers who have agreed to discount their charges. The Plan will consider these providers as participating providers. Covered inpatient medical hospital claims will be considered at 100% of the negotiated amount, subject to the applicable per-admission copayment. Covered services provided by MultiPlan participating professionals are considered based on the MultiPlan negotiated amount less any applicable deductibles and coinsurance.

Dental PPOs

This Plan offers access to a network of dentists who have agreed to provide services at a discounted rate. To find a preferred dentist in your area, call 1-888-788-5702 or visit the Plan's web site www.mhbp.com. For information about the Plan's dental benefits, review this brochure or call the Plan at 1-800-410-7778.

How we pay providers

When you use a PPO provider or facility, our Plan allowance is the negotiated rate for the service. You are not responsible for charges above the negotiated amount.

Non-PPO facilities and providers do not have special agreements with the Plan. Our payment is based on the Plan allowance for covered services. You may be responsible for amounts over the allowance.

If PPO providers are available in your area and you do not use them, your out-of-pocket expenses will increase. The Plan will base its allowance on a fee schedule that represents an average of the PPO fee schedules for a particular service in a particular geographic area (see definition of Plan allowance, page 70, for further details).

When we obtain discounts from MultiPlan participating providers, or through direct negotiations with non-PPO providers, we pass along your share of the savings.

Your Rights

OPM requires that all FEHB Plans provide certain information to their 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.

You can find out about case management, which includes medical practices guidelines, and how we determine if procedures are experimental or investigational.

If you want more information about us, call 1-800-410-7778, or write to: Mail Handlers Benefit Plan, P.O. Box 45118, Jacksonville, FL, 32232-5118. You may also visit our web site at www.mhbp.com.

Section 2. How we change for 2002

Do not rely on these change descriptions; this page 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.

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)
- Four states are added to the list of states designated as medically underserved in 2002: Georgia, Montana, North Dakota and Texas. Louisiana is no longer designated as medically underserved. (Section 3)

Changes to this Plan

- Your share of the non-Postal High Option Self Only premium will increase by 17.2%. For High Option Self and Family your share will increase by 15.4%.
- Your share of the non-Postal Standard Option Self Only premium will increase by 17%. For Standard Option Self and Family your share will increase by 17%.
- We increased the calendar year deductible for High Option from $150 to $200 per person and from $450 to $600 per family.
- We increased the calendar year deductible for Standard Option from $200 to $250 per person and from $600 to $750 per family.
- We cover routine screening for chlamydial infection. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We now cover ostomy supplies under Durable Medical Equipment. Previously, these supplies were covered as prescription drugs.
- We added coverage for one routine cholesterol screening and one routine urinalysis per year.
- We added coverage for outpatient services billed by the outpatient department of a hospital.
- We changed the benefit for services performed and billed in conjunction with an outpatient office visit. Any same-day services (except immunizations or allergy shots) will be subject to the annual deductible and coinsurance.
- We now cover Department of Defense facilities as preferred providers. Previously, overseas facilities were not considered as preferred providers.
- We changed the service provider for the Performance Lab program from LabCorp to Quest Diagnostics.

Section 3. How you get benefits

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-410-7778.

Where you get covered care

You can get care from any "covered provider" or "covered facility." How much we pay – and you pay – depends on the type of covered provider or facility you use. If you use our preferred providers, you will pay less.

- **Covered providers**

We consider the following to be covered providers when they perform covered services within the scope of their license or certification:

- a licensed doctor of medicine (M.D.)
- a licensed doctor of osteopathy (D.O.)
- a licensed doctor of podiatry (D.P.M.)
- a licensed dentist
- a chiropractor
- a licensed clinical physical therapist
- a licensed occupational therapist
- a licensed speech therapist
- a clinical psychologist
- a clinical social worker
- an optometrist
- an audiologist
- an acupuncturist
- a physician's assistant
- a nurse midwife
- a nurse practitioner/clinical specialist
- a nursing school-administered clinic

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2002, the states are: Alabama, Georgia, Idaho, Kentucky, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, and Wyoming.

- **Covered facilities**

Covered facilities include:

- **Freestanding ambulatory facility**. A facility which meets the following criteria: has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis; provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility; does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other professional. The Plan will apply its outpatient surgical facility benefits only to facilities that have been accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory HealthCare (AAAHC), or that have Medicare certification as an ASC facility.
- **Managed In-Network providers**. The Plan may approve coverage of providers who are not currently shown as Covered providers, to provide mental conditions/substance abuse treatment under the managed In-Network benefit. Coverage of these providers is limited to circumstances where the Plan has approved the treatment plan.
- **Hospital**. An institution that is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or any other institution that is operated pursuant to law, under the supervision of a staff of doctors (M.D. or D.O.) and with 24-hour-a-day nursing services, and that is primarily engaged in providing:

  (a) general inpatient acute care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or under its control; or

  (b) specialized inpatient acute medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises under its control, or through a written agreement with a hospital or with a specialized provider of those facilities; or

  (c) a licensed birthing center.

  In no event shall the term "hospital" include any part of a hospital that provides long-term care, rather than acute care, or a convalescent nursing home, or any institution or part thereof that:

  (a) is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged; or

  (b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or

  (c) is operated as a school; or

  (d) is operated as a residential treatment facility regardless of its State licensure or accreditation status.
- **Hospice**. A facility that:

  (a) provides primarily inpatient care to terminally ill patients;

  (b) is licensed/certified by the jurisdiction in which it operates;

  (c) is supervised by a staff of doctors (M.D. or D.O.) with at least one such doctor on call 24 hours a day;

  (d) provides 24-hour-a-day nursing services under the direction of a registered nurse (R.N.) and has a full-time administrator; and

  (e) provides an ongoing quality assurance program.

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any provider you want, but we must approve some care in advance.

Transitional care:

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for other than cause,

you may be able to continue seeing your specialist and receiving any PPO benefits 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 and any PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

Hospital care:

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 relations department immediately at 1-800-410-7778.

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 hospitalized person.

How to get approval for…

• Your hospital stay

Precertification is the process by which — prior to your inpatient hospital admission — we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we won't change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. In addition, if the stay is not medically necessary, we will not pay any benefits for the room and board charges. If the reason for the admission is for services or supplies we don't cover, non-covered cosmetic surgery, for example, we will not pay any benefits.

Any stay greater than 23 hours must be precertified.

How to precertify an admission

- You, your representative, your doctor, or your hospital must call the Plan at least two working days before admission. The toll-free number is 1-800-410-7778.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date and phone number;
  - Reason for hospitalization, proposed treatment or surgery;
  - Name of hospital or facility;
  - Name and phone number of admitting doctor; and
  - Number of planned days of confinement.

We will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Plan's certification decision will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures on the following page.

Emergency admissions

When there is an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 1-800-410-7778 within two business days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by $500.

Maternity care

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then you, your representative, your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then you, your representative, your physician or the hospital must contact us for precertification of additional days for your baby.

If your hospital stay is extended

If your hospital stay — including for maternity care — needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and you did not get the additional days precertified, then:
  - for the part of the admission that we determined was medically necessary, we will pay inpatient benefits, but
  - for the part of the admission that was not medically necessary, we will pay only 70% of the covered medical services and supplies otherwise payable on an outpatient basis and will not pay room and board benefits.
- If no one contacted us, we will decide whether the hospital stay was medically necessary.
  - If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.
  - If we determine that it was not medically necessary for you to be an inpatient, we will not pay room and board hospital benefits. We will only pay 70% for covered medical supplies and services that are otherwise payable on an outpatient basis.
- If we denied the precertification request, we will not pay room and board inpatient hospital benefits. We will only pay 70% for covered medical supplies and services that are otherwise payable on an outpatient basis.

Exceptions

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Your Medicare Part A is the primary payer for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you **do** need precertification.
- Your stay is less than 23 hours.

• Other services

Some services require a referral, precertification, or prior authorization.

- This Plan requires a prior authorization for medically necessary outpatient hospital services provided in connection with dental procedures. Call 1-800-410-7778 to request preauthorization.
- This Plan requires preauthorization of mental conditions/substance abuse services under the managed In-Network benefit. See Section 5(e) page 46.
- This Plan requires preauthorization of certain drugs. See Section 5(f) page 49.

Section 4. Your costs for covered services

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

- **Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your PPO physician you pay a copayment of $15 per visit.

- **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. Copayments and coinsurance do not count toward any deductible.

- The calendar year deductible for covered medical services and supplies is $200 per person under High Option and $250 per person under Standard Option. Under a family enrollment, the medical services and supplies deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $600 under High Option and $750 under Standard Option.
- The calendar year deductible for covered mental and nervous/substance abuse services is $200 per person under High Option and $250 per person under Standard Option. This deductible is in addition to the medical services deductible. Under a family enrollment, the mental and nervous/substance abuse services deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible reach $600 under High Option and $750 under Standard Option.
- The calendar year deductible for prescription drugs is $250 per person under High Option and $600 per person under Standard Option. Under a family enrollment, this deductible is met when the family has incurred $500 under High Option and $1,200 under Standard Option.

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.

And, 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 allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

Example: You pay 30% of our allowance for non-PPO office visits.

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

For example, if your physician ordinarily charges $100 for a covered service but routinely waives your 30% coinsurance, the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

- **Differences between our allowance and the bill**

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service Plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible, coinsurance or copayment. Here is an example: You see a PPO physician for an office visit who charges $150, but our allowance is $100. You are only responsible for your copayment. That is, you pay just $15 of our $100 allowance. Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his bill.
- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance - **plus** any difference between our allowance and the charges on the bill. Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the $50 difference between our allowance and his bill. For details on how we determine the Plan allowance, please see Section 10.
- **MultiPlan** providers agree to limit what they can collect from you. You will still have to pay your deductible and coinsurance. These providers agree to write off the difference between billed charges and the discount amount.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician. The table uses our example of a service for which the physician charges $150 and our allowance is $100. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	$150	$150
Our allowance	We set it at: $100	We set it at: $100
We pay	$85	70% of our allowance: $70
You owe:		
Copayment	$15	30% of our allowance: $30
+ Difference up to charge	No: 0	Yes: 50
TOTAL YOU PAY	$15	$80

Your catastrophic protection (out-of-pocket maximum for coinsurance)

For those services with coinsurance (excluding mental health and substance abuse care), we pay 100% of the Plan allowance for the remainder of the calendar year after your coinsurance expenses total these amounts:

- $2,500 for services of PPO providers/facilities under the High Option
- $4,000 for services of PPO providers/facilities under the Standard Option
- $4,000 for services of PPO and Non-PPO providers/facilities, combined, under the High or Standard Option.

For mental health and substance abuse benefits, we pay 100% of the Plan allowance for the remainder of the calendar year after your coinsurance expenses total these amounts:

- $2,500 for services of In-network providers/facilities under the High Option
- $4,000 for services of In-network providers/facilities under the Standard Option

Your catastrophic protection (out-of-pocket maximum for coinsurance) ***(continued)***

Note: Your out-of-pocket maximum does not apply to these benefits:

- Skilled nursing care
- Prescription drugs
- Any out-of-network mental health and substance abuse care
- Hospice
- Dental services
- Rehabilitative and alternative therapies
- Worldwide Assistance benefit

Note: The following cannot be counted toward out-of-pocket expenses:

- Deductibles
- Copayments
- Expenses incurred under Prescription Drug Benefits
- Expenses in excess of the Plan allowance or maximum benefit limitations
- Any out-of-network expenses for mental health and substance abuse care
- Amounts you pay for non-compliance with this Plan's cost containment requirements
- Coinsurance for skilled nursing care
- Non-covered services and supplies
- Coinsurance for alternative and rehabilitative therapy

When government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service 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.

We pay benefits for Department of Defense facilities as preferred providers.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

When you are age 65 or over and you do not have Medicare

Under the FEHB law, we must limit our payments for those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. The following chart has more information about the limits.

If you…

- are age 65 or over, and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, or a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount — the "equivalent Medicare amount" — set by Medicare's rules for what Medicare would pay, not on the actual charge;
- you are responsible for your coinsurance and any applicable deductibles or copayments you owe under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the Medicare equivalent amount.

And, for your physician care, the law requires us to base our payment and your coinsurance on…

- an amount set by Medicare and called the "Medicare approved amount," or
- the actual charge if it is lower than the Medicare approved amount.

If your physician…	Then you are responsible for…
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is **not** in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are permitted to collect only up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

When Medicare is primary, all or part of your Plan deductibles and coinsurance will be waived as indicated below:

- When Medicare Part A is primary, the Plan will waive applicable per-admission copayments and coinsurance for Inpatient Hospital Benefits and Inpatient Mental Conditions/Substance Abuse Benefits
- When Medicare Part B is primary, the Plan will waive applicable deductibles, copayments and coinsurance for surgical and medical services billed by physicians, durable medical equipment, orthopedic and prosthetic appliances, and ambulance services.
- When Medicare Part B is primary, the Plan will waive the calendar year deductible (but not the coinsurance) for nursing benefits and outpatient mental conditions and substance abuse benefits.
- When Medicare Parts A and B are primary, the Plan will waive the deductible for prescription drugs purchased through the mail order prescription drug program.

Note: The Plan will not waive the deductible and coinsurance for retail prescription drugs.

If your physician does not accept Medicare assignment, the physician may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask the physician to reduce the charges. If the physician does not, report the physician to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

When you have a Medicare Private Contract with a physician

A physician may ask you to sign a private contract agreeing that you can be billed directly for services Medicare ordinarily covers. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Medicare's payment.

Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Section 5. Benefits – OVERVIEW

(*See page 6 for how our benefits changed this year and pages 78-79 for a benefits summary.)*

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-410-7778 or at our web site at www.mhbp.com.

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

Here are some 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 person ($750 per family) for Standard Option and $200 per person ($600 per family) for High Option. 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. See Section 4 for more information about deductibles and other cost-sharing features such as coinsurance and copayments.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay After the calendar year deductible …	
	Standard Option	High Option
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	**You Pay – Standard Option**	**You Pay – High Option**
Professional services of physicians • In physician's office (this includes evaluation and management services related to chemotherapy, hemodialysis and radiation therapy) • At home • In an urgent care center • Office medical consultations • Second surgical opinions provided in a physician's office	PPO: $15 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $15 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Same-day services performed and billed in conjunction with the office visit (except allergy shots, rabies shots or immunizations)	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Diagnostic and treatment services – continued on next page

Diagnostic and treatment services *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Professional services of physicians during a hospital stay Note: Outpatient cancer treatment (chemotherapy, X-rays, or radiation therapy) and dialysis services are paid under Treatment therapy, page 24.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: • *Routine physical checkups and related tests except those covered under preventive care* • *Thermography and related visits* • *Chelation therapy provided in an outpatient setting* • *Orthoptic visits and related services*	*All Charges*	*All Charges*
Lab, X-ray, and other diagnostic tests		
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.
Performance Lab You can use this voluntary program if this Plan is your primary insurance carrier. You show your Mail Handlers Benefit Plan identification card and ask your doctor to send your lab order to Quest Diagnostics. As long as Quest Diagnostics does the testing, you will not have to file any claims. To learn of a location near you, call 1-800-377-7220, or visit the Plan's web site at www.mhbp.com.	Nothing (No deductible)	Nothing (No deductible)
Not Covered: • *Handling and administrative charges* • *Routine lab services except as covered under Preventive care*	*All charges*	*All charges*

Preventive care, adult	You Pay — Standard Option	You Pay — High Option
Routine screenings, limited to: • Mammogram for women age 35 and older: – From age 35 to 39 — one during this five year period – From age 40 to 64 — one every calendar year – At age 65 and older — one every two consecutive calendar years • Pap smear — one per calendar year for women age 18 and older Note: The office visit is covered if pap test is received on the same day. • Prostate Specific Antigen (PSA) — one per calendar year for men age 40 and older • Colorectal cancer screening, including: – Fecal occult blood (stool) test — one per calendar year for members age 40 and older – Screening sigmoidoscopy — one every two consecutive calendar years for members age 50 and older • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members • Chlamydial infection screening	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Routine immunizations provided during an office visit	PPO: $15 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $15 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Not Covered: *Routine physical checkups and related tests except those listed above*	*All Charges*	*All Charges*

Preventive care, children	You Pay — Standard Option	You Pay — High Option
Childhood immunizations recommended by the American Academy of Pediatrics for members under age 22	PPO: Nothing (No deductible) Non-PPO: The difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: The difference between our allowance and the billed amount (No deductible)
Well-child visits to a doctor for covered dependents up to age 18	PPO: $15 copayment per office visit (No deductible). All charges after the Plan has paid $100 per child per calendar year. Non-PPO: All charges after the Plan has paid $75 per child per calendar year (No deductible)	PPO: $15 copayment per office visit (No deductible). All charges after the Plan has paid $100 per child per calendar year. Non-PPO: All charges after the Plan has paid $75 per child per calendar year (No deductible)
Routine screenings, limited to: • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount

Maternity care	You Pay — Standard Option	You Pay — High Option
Complete maternity (obstetrical) care, including: • Pre-natal care • Delivery • Anesthesia • Post-natal care Note: Here are some things to keep in mind: • You do not need to precertify your admission for a normal delivery; see page 10 for other circumstances such as extended stays for you or your baby. • You may remain in the hospital/birthing center up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you, your representative, your doctor or your hospital must precertify. • 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 if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon's services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)). • Newborn exams are payable under Section 5(a). • Newborn charges incurred as a result of illness, are considered expenses of the child, not the mother, and are subject to a separate precertification and separate inpatient copayment. • Maternity benefits will be paid at the termination of pregnancy.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: • *Standby doctors* • *Home uterine monitoring devices* • *Services provided to the newborn if the infant is not covered under a self and family enrollment*	*All Charges*	*All Charges*

Family planning	You Pay — Standard Option	You Pay — High Option
Voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Intrauterine devices (IUDs)	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
• Injectable contraceptive drugs (such as Depo provera) Note: We cover oral contraceptive drugs in Section 5(f).	PPO: $15 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $15 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization*	*All Charges*	*All Charges*
Infertility services		
Diagnosis and treatment of infertility, except as shown in *Not covered* Note: Certain prescription drugs for the treatment of infertility are covered under Prescription drug benefits. Call the Plan for a list of drugs that are covered for this service, or go to www.mhbp.com for a link to the list.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures such as:* – *artificial insemination* – *in vitro fertilization* – *embryo transfer and Gamete Intrafallopian Transfer (GIFT)* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All Charges*	*All Charges*

Allergy care	You Pay — Standard Option	You Pay — High Option
Testing, including materials	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Allergy serum	PPO: $5 copayment (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $5 copayment (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Allergy injections (not including allergy serum)	PPO: $5 copayment per visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $5 copayment per visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: *Any services or supplies considered by the National Institute of Health and the National Institute of Allergy and Infectious Disease to be not effective to diagnose allergies and/or not effective in preventing an allergy reaction*	*All Charges*	*All Charges*

Treatment therapy	You Pay — Standard Option	You Pay — High Option
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 37. • Dialysis — Hemodialysis and peritoneal dialysis • Intravenous (IV)/Antibiotic Infusion Therapy • Hyperbaric oxygen therapy • Treatment room • Observation room Note: These therapies (excluding the related office visits) are covered under this benefit when billed by the outpatient section of a hospital, clinic or a physician's office. Retail pharmacy charges for chemotherapy and prescription drugs to treat the side effects of chemotherapy are covered under Prescription Drugs, see Section 5(f).	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Rabies shots and related services	Nothing	Nothing
Not covered: • *Chelation therapy, except if the covered services and supplies are provided during a precertified inpatient admission* • *Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered under Section 5(b)*	*All Charges*	*All Charges*

Rehabilitative therapies	You Pay — Standard Option	You Pay — High Option
Outpatient physical therapy, speech therapy, and occupational therapy Note: The annual $2,000 combined rehabilitative, chiropractic and alternative therapies maximum includes all covered services and supplies billed for these therapies.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.
Not covered: • *Charges billed after the Plan has paid the combined $2,000 rehabilitative, chiropractic and alternative treatment therapies maximum* • *Exercise programs*	*All Charges*	*All Charges*

Hearing services (testing, treatment and supplies)	**You Pay — Standard Option**	**You Pay — High Option**
One hearing aid per ear and related services are covered only when the hearing loss was caused by an accidental injury. The hearing aid must be purchased within 120 days of the accident and the patient must be covered by the Plan at the time of purchase. Note: The calendar year deductible applies.	All charges over $200 for one hearing aid per ear	All charges over $200 for one hearing aid per ear
Testing (non-routine) Note: The calendar year deductible applies.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: *Routine hearing tests, hearing aids, and related services when the hearing loss is not directly related to an accidental injury*	*All Charges*	*All Charges*
Vision services (testing, treatment and supplies)		
One pair of eyeglasses or contact lenses to correct an impairment directly caused by an accidental ocular injury or intraocular surgery (such as for cataracts). The eyeglasses or contact lenses must be purchased within one year of the injury or surgery and the patient must be covered by the Plan at the time of purchase. Note: The calendar year deductible applies.	All charges over $50 for one set of eyeglasses or $100 for contact lenses (including examination)	All charges over $50 for one set of eyeglasses or $100 for contact lenses (including examination)
Not covered: • *Routine eye exams* • *Eye glasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery* • *Eye exercises, refractions and related office visits* • *Radial keratotomy including laser keratotomy and other refractive surgery*	*All Charges*	*All Charges*

Foot care	You Pay — Standard Option	You Pay — High Option
We pay the professional services for routine foot care for established diabetics. We also pay for medically necessary surgeries under the surgery benefit. See Section 5(b).	PPO: $15 copayment per office visit (No deductible), and 10% of the Plan's allowance for other services performed during the visit (deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (deductible applies)	PPO: $15 copayment per office visit (No deductible), and 10% of the Plan's allowance for other services performed during the visit (deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (deductible applies)
Not Covered: *Cutting, trimming and removal of corns, calluses or the free edge of toenails, and similar routine treatment of conditions of the foot except for the established diagnosis of diabetes*	*All Charges*	*All Charges*
Orthopedic and prosthetic devices		
Orthopedic and prosthetic devices (see Definitions — Section 10) when recommended by an MD or DO, including: Artificial limbs and eyes, stump hose; Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy; Note: Call the Plan to locate a vendor.	10% of the Plan's allowance	10% of the Plan's allowance
Not Covered: • *Orthopedic and corrective shoes unless attached to a brace* • *Arch supports* • *Foot orthotics and related office visits* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered unless a replacement is needed for medical reasons* • *Penile prosthetics*	*All Charges*	*All Charges*

Durable medical equipment	You Pay — Standard Option	You Pay — High Option
Durable Medical Equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment such as oxygen and dialysis equipment. The Plan will limit its benefit for the rental of durable medical equipment to an amount no greater than what it would have paid if the equipment had been purchased. Under this benefit we also cover: • Wheelchairs • Hospital beds • Oxygen equipment • Ostomy supplies (including supplies purchased at a pharmacy) Note: Call us at 1-800-410-7778 to get information about durable medical equipment PPO providers. Any equipment billed by rehabilitative therapists or alternative medicine providers is covered under that benefit and subject to the combined annual maximum. Note: For those members who have Medicare Part B as their primary payer, diabetic supplies will be covered under this benefit.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount

Durable medical equipment – continued on next page

Durable medical equipment *(continued)*	**You Pay — Standard Option**	**You Pay — High Option**
Not Covered: • *Equipment replacements provided less than 3 years after the last one we covered* • *Charges for service contracts for purchased equipment* • *Safety, hygiene, convenience and exercise equipment* • *Household or vehicle modifications including seat, chair or van lifts; computer switchboard* • *Communication equipment including computer "story boards," "light talkers," and enhanced vision systems* • *Air conditioners, air purifiers, humidifiers, ultraviolet lighting (except for the treatment of psoriasis)* • *Wigs or hair pieces* • *Motorized scooters, lifts, ramps, prone standers and other items that do not meet the DME definition* • *Dental appliances used to treat sleep apnea and/or temporomandibular joint dysfunction* • *Charges for educational/instructional advice on how to use the durable medical equipment* • *All rental charges above the purchase price*	*All Charges*	*All Charges*

Home health services – (nursing services)	You Pay — Standard Option	You Pay — High Option
A registered nurse (R.N.) or licensed practical nurse (L.P.N.) is covered for outpatient services when: • Prescribed by your attending physician (i.e., the physician who is treating your illness or injury) for outpatient services; • The physician indicates the length of time or number of visits the services are needed; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $700 annual maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid $700 for these services.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $700 annual maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid $700 for these services.
Not covered: • *Inpatient private duty nursing* • *Nursing care requested by, or for the convenience of, the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *All charges after the Plan has paid $700 for covered nursing services*	*All Charges*	*All Charges*
Chiropractic		
Chiropractic care • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: The annual $2,000 combined rehabilitative, chiropractic and alternative treatment therapies maximum includes all covered services and supplies billed for these therapies.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.

Alternative treatment	You Pay — Standard Option	You Pay — High Option
Acupuncture Note: The annual $2,000 combined rehabilitative, chiropractic and alternative treatment therapies maximum includes all covered services and supplies billed for these therapies.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.
Not covered: • *Naturopathic and homeopathic services* • *Chelation therapy, except if the covered services and supplies are provided during a precertified inpatient hospitalization* • *Thermography, biofeedback and related visits* • *Charges after the $2,000 combined rehabilitative, chiropractic therapies and alternative treatments annual maximum has been paid by the Plan* *Note: Services of certain alternative treatment providers may be covered in medically underserved areas — see page 7.*	*All Charges*	*All Charges*
Educational classes and programs		
Smoking Cessation — Up to $100 for one smoking cessation program per member per lifetime Note: All benefits are paid directly to you. Smoking deterrents are covered under prescription drugs. See Section 5(f).	All charges over $100	All charges over $100
Not Covered: • *Self help or self management programs such as diabetic self management* • *Charges for educational/instructional advice on how to use durable medical equipment*	*All Charges*	*All Charges*

Section 5 (b). Surgical and anesthetic services provided by physicians and other health care professionals

Here are some 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 person ($750 per family) for Standard Option and $200 per person ($600 per family) for High Option. 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. See Section 4 for more information about deductibles and other cost-sharing features such as coinsurance and copayments.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgery. Look in Section 5(c) for charges associated with the facility charge (i.e. hospital, surgical center, etc.).
- **PLEASE REMEMBER THAT ANY SURGICAL SERVICES THAT REQUIRE AN INPATIENT ADMISSION MUST BE PRECERTIFIED**. Please refer to the precertification information shown in Section 3.

Benefit Description	You Pay After the Calendar Year deductible …	
	Standard Option	High Option
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**You Pay – Standard Option**	**You Pay – High Option**
A comprehensive range of services, such as: • Operative procedures (performed by the primary surgeon) • Treatment of fractures, including casting; • Normal pre- and post-operative care by the surgeon; • Endoscopy procedures (diagnostic and surgical); • Biopsy procedures; • Electroconvulsive therapy; • Removal of tumors and cysts; • Correction of congenital anomalies (see Reconstructive surgery);	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount

Surgical procedures – continued on next page

Surgical procedures *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
• Surgical treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over; • Insertion of internal prosthetic devices (See Section 5(a) — Orthopedic and prosthetic devices — for device coverage information); • Voluntary sterilization, Norplant (a surgically implanted contraceptives), and intrauterine devices (IUDs); • Treatment of burns; • Correction of amblyopia & strabismus.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures are performed during the same operative session by the same surgeon, the Plan's benefit is determined as follows: • For the primary procedure: – PPO: the Plan's full allowance or – Non-PPO: the Plan's full allowance • For the secondary procedure: – PPO: one-half of the Plan's allowance or – Non-PPO: one-half of the Plan's allowance • For the tertiary procedure and any other subsequent procedures: – PPO: one-quarter of the Plan's allowance or – Non-PPO: one-quarter of the Plan's allowance	PPO: 10% of the Plan's allowance for the individual procedure Non-PPO: 30% of the Plan's allowance for the individual procedure and any difference between the Plan's allowance and the billed amount	PPO: 10% of the Plan's allowance for the individual procedure Non-PPO: 30% of the Plan's allowance for the individual procedure; and any difference between the Plan's allowance and the billed amount

Surgical Procedures – continued on next page

Surgical procedures *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Co-surgeons When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 50% of what it would pay a single surgeon for the same procedure(s).	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Assistant surgeon When a surgery requires an assistant surgeon, the Plan will reduce its benefits for the assistant surgeon to 20% of the allowance for the surgery.	PPO: Nothing Non-PPO: The difference between our allowance and the billed amount	PPO: Nothing Non-PPO: The difference between our allowance and the billed amount
Not covered: • *Multiple or bilateral surgical procedures performed through the same incision that are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.* • *Reversal of voluntary sterilization* • *Services of a standby surgeon* • *Routine treatment of conditions of the foot except for services rendered to established diabetics* • *Cosmetic surgery (See definition, page 35)* • *Radial keratotomy, laser and other refractive surgery*	*All Charges*	*All Charges*

Reconstructive surgery	You Pay — Standard Option	You Pay — High Option
• Surgery to correct a functional defect; • Surgery to correct a condition caused by injury or illness if: The condition produces a major effect on the member's appearance, and The condition can reasonably be expected to be corrected by such surgery. Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. All stages of breast reconstruction surgery following a mastectomy, such as: • Surgery to produce a symmetrical appearance on the other breast; • Treatment of any physical complications, such as lymphedemas. (See Prosthetic devices for coverage of breast prostheses and surgical bras and replacements.) Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: • *Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through a change in bodily form, except repair of accidental injury or caused by illness* • *Surgery related to sex transformation or sexual dysfunction*	*All Charges*	*All Charges*

Oral and maxillofacial surgery	You Pay — Standard Option	You Pay — High Option
Oral surgical procedures limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of impacted teeth that are not completely erupted (bony, partial bony, and soft tissue impactions); • Removal of stones from salivary ducts; • Excision of leukoplakia, tori or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Temporomandibular joint dysfunction surgery; • Other surgical procedures that do not involve the teeth or their supporting structures. Note: The related hospitalization (inpatient and outpatient) are covered if medically necessary. See Section 5(c).	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Oral/dental implants and transplants;* • *Procedures that involve the teeth or their supporting structures, such as the periodontal membrane, gingiva, and alveolar bone(these procedures may be considered as covered dental procedures under the High Option dental benefits);* • *Conservative treatment of temporomandibular joint dysfunction (TMJ)*	*All Charges*	*All Charges*

Organ/tissue transplants	You Pay — Standard Option	You Pay — High Option
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Pancreas • Single lung • Double lung • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Allogenic (donor) bone marrow transplants for chronic myelogenous leukemia, acute leukemia, aplastic anemia, severe combined immuno-deficiency disease, Wiscott-Aldrich syndrome, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphomas, and myelodysplastic syndrome (in advanced form). • Autologous (self) bone marrow transplants (autologous stem cell and peripheral stem cell support) for chronic or acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphomas; resistant or recurrent neuroblastoma; testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. Surgical transplant of body organ/tissue means transfer of a body organ(s) tissue(s) from the donor to the recipient (allogenic) or a bone marrow graft in which the donor and recipient are the same person (autologous).	PPO: 10% of the Plan's allowance and all charges over $300,000 Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $300,000. Note: The maximum benefit for any organ/tissue transplant(s) is $300,000 per occurrence. Included in the $300,000 maximum are hospital, surgical, and medical expenses of the recipient but not the covered expenses of the donor. Benefits issued for charges related to complications arising during the transplant confinement (same admission) are subject to the $300,000 maximum. The cost of outpatient prescription drugs related to the transplant is not subject to the $300,000 limit. Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support, is covered only for the specific diagnoses listed.	PPO: 10% of the Plan's allowance and all charges over $300,000 Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $300,000. Note: The maximum benefit for any organ/tissue transplant(s) is $300,000 per occurrence. Included in the $300,000 maximum are hospital, surgical, and medical expenses of the recipient but not the covered expenses of the donor. Benefits issued for charges related to complications arising during the transplant confinement (same admission) are subject to the $300,000 maximum. The cost of outpatient prescription drugs related to the transplant is not subject to the $300,000 limit. Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support, is covered only for the specific diagnoses listed.

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You Pay — Standard Option**	**You Pay — High Option**
Not covered: • *Donor screening tests and donor search expenses, except those performed on the actual donor;* • *Services and supplies for or related to transplants not listed as covered.* • *Related services or supplies include administration of chemotherapy when supported by transplant procedures.*	*All Charges*	*All Charges*
Anesthesia		
Professional services for the administration of anesthesia in hospital and out of hospital.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.

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

Here are some 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.
- Unlike Sections 5(a) and 5(b), in this section the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". If applicable, the calendar year deductible is $250 per person ($750 per family) for Standard Option and $200 per person ($600 per family) for High Option.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. 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).
- Note: When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists may not all be preferred providers.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY**. Please refer to the precertification information listed in Section 3 to be sure which services require precertification.

Benefit Description	You Pay	
	Standard Option	High Option
NOTE: The calendar year deductible applies only when we say below: "(calendar year deductible applies)".		
Inpatient hospital	**You Pay – Standard Option**	**You Pay – High Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations, including birthing centers; • general nursing care; and • meals and special diets. Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations.	PPO: $150 per admission Non-PPO: $300 per admission	PPO: Nothing Non-PPO: $250 per admission

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Pathology tests • Diagnostic laboratory and X-rays • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Autologous blood donations • Internal prosthesis Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its anesthetists' services, we pay Hospital benefits and when the anesthetist bills directly we pay under Section 5(b) Surgical and Anesthesia Services benefits. Note: The maximum benefit for any organ/tissue transplant, as described on page 37 is $300,000 per occurrence. Benefits issued for charges related to complications arising during the transplant confinement (same admission) is subject to the $300,000 maximum. Included in the $300,000 maximum are hospital, surgical, and other medical expenses. The cost of related outpatient prescription drugs is not subject to this limit. Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support is covered only for the specific diagnoses listed on page 37. Note: The Plan pays Inpatient Hospital Benefits as shown above in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient.	See page 39	See page 39

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Not covered: • *A hospital admission, or portion thereof, that is not medically necessary (see definition), including an admission for medical services that did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered.* • *Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day.* • *Custodial care; see Section 10: Definitions.* • *Non-covered facilities, such as nursing homes, subacute care facilities, extended care facilities, schools, domiciliaries and rest homes.* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds.* • *Private inpatient nursing care.* • *Institutions that do not meet the definition of covered hospitals.*	*All Charges*	*All Charges*

Outpatient hospital, freestanding ambulatory surgical center, or clinic	You Pay — Standard Option	You Pay — High Option
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including anesthesia and oxygen • Anesthetics and anesthesia services Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. Note: If the stay is greater than 23 hours, you need to precertify the admission. Note: For services billed by the surgeon and the anesthetist, see Section 5(b), Surgical and anesthetic services provided by physicians and other health care professionals.	PPO: Nothing after the calendar year deductible Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: Nothing after the calendar year deductible Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: *Surgical facility charges billed by entities that are not accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory HealthCare (AAAHC), or which do not have Medicare certification as an ASC facility.*	*All charges*	*All charges*
Extended care benefit/skilled nursing care facility benefit		
No benefit	*All Charges*	*All Charges*

Hospice care	You Pay — Standard Option	You Pay — High Option
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. • We pay $5,000 per lifetime for any combination of inpatient and outpatient services. If you use a PPO provider, your out-of-pocket expenses will be reduced.	PPO: All charges after the Plan has paid $5,000 Non-PPO: All charges after the Plan has paid $5,000	PPO: All charges after the Plan has paid $5,000 Non-PPO: All charges after the Plan has paid $5,000
Not covered: • *Independent nursing, and homemaker services* • *Charges above $5,000.*	*All Charges*	*All Charges*
Ambulance		
Local professional ambulance service when medically appropriate to the first hospital where treated and from that hospital to the next nearest hospital or medical facility if necessary treatment is not available at the first hospital Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition requires immediate evacuation	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: Non-medically necessary transport	*All Charges*	*All Charges*

Section 5 (d). Emergency services/accidents

Here are some 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 person ($750 per family) for Standard Option and $200 per person ($600 per family) for High Option. 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. See Section 4 for more information about deductibles and other cost-sharing features such as coinsurance and copayments.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay After the Calendar Year deductible …	
	Standard Option	High Option
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury	**You Pay – Standard Option**	**You Pay – High Option**
If you receive outpatient care for your accidental injury in a hospital emergency room or urgent care center, we cover: • Non-surgical physician services and supplies; • Related outpatient hospital services; • Observation room; • Surgery. Note: We pay inpatient hospital benefits if you are admitted. Note: Repair of sound natural teeth due to an accidental injury is covered under this benefit. The services and supplies must be provided within one year of the accident and the patient must be a member of the Plan at the time the services were rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount

Accidental injury – continued on next page

Accidental injury *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Non-surgical physician services provided in a doctor's office for your accidental injury.	PPO: $15 copayment per office visit (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)	PPO: $15 copayment per office visit (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)
Medical emergency		
Outpatient medical or surgical services and supplies for services rendered in a hospital emergency room or urgent care center (including observation room)	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Non-surgical physician services and supplies provided in a doctor's office	PPO: $15 copayment per office visit (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)	PPO: $15 copayment per office visit (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)
Ambulance		
Local professional ambulance service when medically appropriate to the first hospital where treated and from that hospital to the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition warrants immediate evacuation.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: When used for non-emergency purposes	*All Charges*	*All Charges*

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

You may choose to get care Out-of-Network or In-Network. When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits of other illnesses and conditions. If In-Network care is not authorized, Out-of-Network benefits will be paid.

Here are some 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 and/or clinically appropriate.
- The Mental health and substance abuse benefits calendar year deductible is $250 per person ($750 per family) for Standard Option and $200 per person ($600 per family) for High Option. 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. This calendar year deductible is in addition to the calendar year deductible for medical services and the calendar year deductible for prescription drugs.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- If you do not obtain and follow an approved treatment plan we will provide Out-of-Network benefits.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES**. See the instructions after the benefits descriptions below.

. In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 48.

Benefit Description	You Pay After the Calendar Year deductible …	
	Standard Option	**High Option**
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Managed In-Network Benefits	**You Pay – Standard Option**	**You Pay – High Option**
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Managed In-Network 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	Your cost sharing responsibilities are no greater than for other illnesses or conditions
• Outpatient professional services, including individual or group therapy by providers approved by the Managed In-Network vendor. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist. • Medication management	$15 copayment per office visit (No deductible)	$15 copayment per office visit (No deductible)

Managed In-Network Benefits – continued on next page

Managed In-Network Benefits *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
• Inpatient professional services	10% of the Plan's allowance	10% of the Plan's allowance
• Electroshock therapy and laboratory procedures • Diagnostic tests including psychological testing	10% of the Plan's allowance	10% of the Plan's allowance
• Services provided by a hospital or other inpatient facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$150 per admission	Nothing
Not covered: Services we have not approved	*All Charges*	*All Charges*
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.		

Preauthorization — To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and the following network authorization process:

Call the Plan at 1-800-410-7778 to be referred to the Managed Network vendor. If you do not call, the charges will be processed as Out-of-Network benefits.

Network Limitation — If you do not obtain an approved treatment plan we will provide only Out-of-Network benefits

Out-of-Network benefits for services and supplies provided by Out-of-Network providers or services and supplies not approved by us	You Pay – Standard Option	You Pay – High Option
Outpatient professional services to treat mental conditions and substance abuse Note: One day in partial hospitalization/day treatment program is considered as one outpatient visit	30% of the Plan's allowance for up to 20 visits after the mental conditions/substance abuse calendar year deductible and any difference between our allowance and the billed amount. All charges after 20 visits.	30% of the Plan's allowance for up to 20 visits after the mental conditions/substance abuse calendar year deductible and any difference between our allowance and the billed amount. All charges after 20 visits.
Inpatient professional services to treat mental conditions and substance abuse	30% of the Plan's allowance after the mental conditions/substance abuse calendar year deductible. And any difference between our allowance and the billed amount.	30% of the Plan's allowance after the mental conditions/substance abuse calendar year deductible. And any difference between our allowance and the billed amount.
Electroshock therapy, diagnostic tests and laboratory procedures	30% of the Plan's allowance after the mental conditions/substance abuse calendar year deductible. And any difference between our allowance and the billed amount.	30% of the Plan's allowance after the mental conditions/substance abuse calendar year deductible. And any difference between our allowance and the billed amount.
Inpatient care to treat mental conditions includes ward or semiprivate accommodations and other hospital charges	$300 per admission and 30% of covered charges for up to 45 days per calendar year. And any charges for services rendered after the covered 45 days.	$250 per admission and 30% of covered charges for up to 45 days per calendar year. And any charges for services rendered after the covered 45 days.
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	$300 per admission and 30% of covered charges for up to 45 days per calendar year. And any charges for services rendered after the covered 45 days.	$250 per admission and 30% of covered charges for up to 45 days per calendar year. And any charges for services rendered after the covered 45 days.
Not covered Out-of-Network: • *Services, that in the Plan's judgement, are not medically necessary* • *Services by pastoral, marital, drug/alcohol and other counselors* • *Treatment for learning disabilities and mental retardation* • *Services rendered or billed by schools, licensed residential treatment centers or halfway houses or members of their staffs*	*All Charges*	*All Charges*

Precertification The medical necessity of your **admission** to a hospital or other covered facility must be precertified for you to receive these Out-of-Network benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See Section 3 for details.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services*, for information about out-of-pocket maximum for In-Network benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting Out-of-Network claims.

Section 5 (f). Prescription drug benefits

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

- Please remember 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 deductible for prescription drugs is separate from the annual deductible for medical benefits and separate from the annual deductible for mental health and substance abuse. We added "(No deductible)" to show when the calendar year prescription drug deductible does not apply.
- The Calendar Year prescription drug deductible is $600 per person ($1,200 per family) for Standard Option. The Plan will waive the prescription deductible for mail order purchases for members who have Medicare Parts A and B as their primary coverage.
- The Calendar Year prescription drug deductible is $250 per person ($500 per family) for High Option. The Plan will waive the prescription deductible for mail order purchases for members who have Medicare Parts A and B as their primary coverage.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. 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 physician or other covered provider acting within the scope of their license.
- **Where you can obtain them?** You may fill the prescription at an AdvancePCS participating pharmacy, a non-AdvancePCS pharmacy or by mail for certain drugs. We pay a higher level of benefits when you use an AdvancePCS participating pharmacy.

  Network pharmacy – Present your Plan identification card at an AdvancePCS participating Network pharmacy to purchase prescription drugs. Call 1-800-410-7778 to locate the nearest network pharmacy. You must have the pharmacy file the claim electronically for you in order to receive the network pharmacy level benefit.

  Non-Network pharmacy – You may purchase prescriptions at pharmacies that are not part of our network. You pay full cost and must file a claim for reimbursement. See When you have to file a claim.

  Mail order – To obtain more information about the mail order drug program, call the Plan at 1-800-410-7778 or visit our web site at www.mhbp.com.
- **We administer an open formulary.** If your physician believes a brand name drug is necessary or there is no generic available, your physician may prescribe a brand name drug from a formulary list. This formulary list is our preferred brand. This is a list of drugs selected to meet patients needs at a lower cost. To order a prescription drug brochure, call 1-800-410-7778.
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name. If you receive a brand name drug when a Federally-approved generic drug is available, and your physician has not specified "dispense as written" for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.
- **There are dispensing limitations.** All prescriptions will be limited to a 90 day dispensing amount. Also, in most cases, refills cannot be obtained until 75% of the drug has been used. In addition to the general dispensing limitations described above, there are restrictions on certain types of drugs. The Plan requires prior authorization for the following drugs: growth hormones, acne medications, antiemetics (antinausea drugs), migraine medications, drugs used to treat Attention Deficit Disorder and narcolepsy. The Plan may further limit the dispensing quantities for some categories of drugs. These categories include drugs to treat migraine headaches, medications used for nausea and the medications to treat influenza.
- **Why use generic drugs?** A generic drug is the therapeutic equivalent to a brand name drug, yet it costs much less. Choosing generic drugs rather than brand name drugs can reduce your out-of-pocket expenses. 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. They must contain the same active ingredients, be equivalent in strength and dosage, and meet the same standards for safety, purity and effectiveness as the original brand name product.
- **When you have to file a claim.** If you purchase prescriptions at a non-network pharmacy, mail your prescription receipts to: AdvancePCS , Attn: MHBP Claims, P.O. Box 52151, Phoenix, AZ 85072-2151. Receipts must include the prescription number, name of drug, prescribing doctor's name, date, charge and name of drugstore.

Note: All drugs are not available through the mail order program. Some of the drug classes that are not available are: all injectables (except for diabetic supplies and multiple sclerosis agents Betaseron, Avonex, and Copaxone), narcotics, hospital solutions and certain drugs such as antipsychotic agents and AIDS therapies and other drugs for which state or federal laws or medical judgement limit the dispensing amount to less than 90 days. However, these excluded drugs are covered under the retail prescription drug program.

This Plan has two levels of reimbursement for retail prescription drug claims. One is for prescriptions filled at a network pharmacy or for prescriptions filled by foreign pharmacies. The second is for prescriptions filled at a non-network pharmacy or other vendor or when you choose to submit a paper claim to the Plan. It is in your best interest to have your prescription filled at a network pharmacy. If you do not and do not live overseas, your reimbursement will be reduced.

If you submit a paper claim for drugs dispensed by a network pharmacy, the Plan will reduce your benefits to 50% of the allowable charges. Remember to show your Mail Handlers Benefit Plan ID card with the AdvancePCS logo to receive increased benefits. In addition, the claims will be filed electronically for you.

Benefit Description	You Pay After the Calendar Year deductible …	
	Standard Option	**High Option**
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 accessories	**You Pay – Standard Option**	**You Pay – High Option**
You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail (for certain prescription drugs): • Drugs and medicines that by Federal law of the United States require a doctor's written prescription, including chemotherapy and drugs used to treat the side effects of chemotherapy • Disposable needles and syringes, and alcohol swabs (if purchased at a pharmacy). • Insulin and related testing material • Hormone based contraceptives, including Norplant (Norplant insertions are covered under Surgical Benefits) • Diaphragms • Smoking deterrents	Network pharmacies or prescriptions filled by foreign pharmacies: 30% of the Plan's allowance for the prescription Non-network pharmacies: 50% of the Plan's allowance for the prescription Paper claims for prescriptions filled at a network pharmacy: 50% of the Plan's allowance for the prescription Mail Order: $10 per generic/$40 per preferred brand/$55 per non-preferred brand drug Mail Order Medicare: $10 per generic/$40 per preferred brand/$55 per non-preferred brand drug (No deductible)	Network pharmacies or prescriptions filled by foreign pharmacies: 25% of the Plan's allowance for the prescription Non-network pharmacies: 50% of the Plan allowance for the prescription. Paper claims for prescriptions filled at a network pharmacy: 50% of the Plan's allowance for the prescription Mail Order: $10 per generic/$30 per preferred brand/$45 per non-preferred brand drug Mail Order Medicare: $10 per generic/$30 per preferred brand/$45 per non-preferred brand drug (No deductible)

Covered medications and accessories – continued on next page

Covered medications and accessories *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Prescriptions written by a non-covered provider* • *Drugs that do not require a prescription* • *Not medically necessary vitamins and food supplements* • *Vitamins, nutrients and food supplements that do not require a prescription even if a physician prescribes or administers them* • *Nonprescription medicines* • *Anorexiants/appetite suppressants or prescription drugs for weight loss* • *Drugs prescribed for sexual dysfunction or sexual inadequacies* • *Drugs and supplies when another insurance plan or payer provides benefits for these services/supplies except Medicare Part B covered diabetic supplies* • *Any amount in excess of the cost of a generic drug when a generic is available and the physician has not specified that the pharmacist dispense the brand name drug only*	*All charges*	*All charges*

Section 5 (g). Special features

Special Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Worldwide Assistance	This program gives you help and follow-up in medical and other emergencies 100 miles or more from your home. A toll-free number gives you access to expert assistance while traveling. Your ID card and letter will contain more information. Note: Services provided under this benefit through Worldwide Assistance are not subject to the FEHB disputed claims process.

Section 5 (h). Dental Benefits for High Option only

Here are some 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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- High Option pays actual charges up to the amounts specified in the schedule of dental allowances for covered dental procedures, up to a maximum benefit of $800 per person and $1,600 per family per calendar year.
- There is no deductible for High Option Dental Benefits.
- For covered dental procedures not shown, the Plan will pay, subject to the limits provided, amounts consistent with procedures which are shown.

Note: We cover hospitalization for these dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. The hospitalization for both inpatient and outpatient must be precertified by the Plan.

- Dental PPO — The Plan offers access to a network of dentists who have agreed to provide services at a discounted rate. To learn of a preferred dentist in your area, call 1-888-788-5702 or visit the Plan's web site www.mhbp.com. For information about the Plan's benefits, call customer relations at 1-800-410-7778 or visit the Plan's web site.
- The Plan is unable to return dental X-rays. Remind your dentist not to submit X-rays.
- If in the construction of a denture or any prosthetic dental appliance, the patient and the dentist decide on personalized restoration or to employ special techniques as opposed to standard procedures, the benefit provided will be limited to the amount payable for the standard procedures.
- Charges for crowns, bridges, and dentures are usually incurred when they are ordered. The Plan pays benefits to cover such charges even if the enrollee later rejects the denture or appliance.

The following is a partial schedule of dental allowances.

Dental benefits

ADA Code	Service	We Pay (scheduled allowance)	You Pay
	DIAGNOSTIC		
00120	Periodic oral examination (limit one per year)	$ 7.50	All charges above scheduled allowance.
00210	X-rays, intraoral, complete series including bitewings (limit one per year)	22.00	All charges above scheduled allowance.
00220	X-rays, intraoral, periapical — first film	3.25	All charges above scheduled allowance.
00230	X-rays, intraoral, periapical — each additional film	2.25	All charges above scheduled allowance.
00240	X-rays, intraoral, occlusal film	7.50	All charges above scheduled allowance.
00270	X-rays, bitewing, single film	2.75	All charges above scheduled allowance.
00290	X-rays, posterior-anterior or lateral skull and facial bone survey	13.00	All charges above scheduled allowance.
00330	X-rays, panoramic film	22.00	All charges above scheduled allowance.

Dental benefits – continued on next page

Dental benefits *(continued)*

ADA Code	Service	We Pay (scheduled allowance)	You Pay
	PREVENTIVE (dollar amount shown is limit per calendar year)		
01110	Prophylaxis, adult (age 13 and over)	$ 14.25	All charges above scheduled allowance.
01120	Prophylaxis, child (through age 12)	12.00	All charges above scheduled allowance.
01203	Fluoride application, topical, child	7.50	All charges above scheduled allowance.
01204	Fluoride application, topical, adult	7.50	All charges above scheduled allowance.
01351	Sealant, per tooth	7.50	All charges above scheduled allowance.
01510	Space maintainer, fixed, unilateral (limited to age 18 and under)	34.00	All charges above scheduled allowance.
	RESTORATIVE (includes liners, bases and local anesthesia)		
02140	One surface, permanent	$ 13.00	All charges above scheduled allowance.
02150	Two surfaces, permanent	20.75	All charges above scheduled allowance.
02160	Three surfaces, permanent	27.50	All charges above scheduled allowance.
02951	Reinforcement pins, each pin	8.25	All charges above scheduled allowance.
	ENDODONTICS (includes local anesthesia)		
03110	Pulp cap, direct	$ 16.50	All charges above scheduled allowance.
03310	Root canal therapy, one canal	96.75	All charges above scheduled allowance.
03320	Root canal therapy, two canals	136.25	All charges above scheduled allowance.
03330	Root canal therapy, three canals	178.00	All charges above scheduled allowance.
03410	Apicoectomy	55.00	All charges above scheduled allowance.
	PERIODONTICS (includes local anesthesia)		
04320	Provisional splinting	$ 81.25	All charges above scheduled allowance.
04341	Periodontal scaling and root planing (per quadrant)	13.00	All charges above scheduled allowance.
04910	Periodontal maintenance procedures	13.00	All charges above scheduled allowance.

Dental benefits – continued on next page

Dental benefits *(continued)*			
ADA Code	**Service**	**We Pay (scheduled allowance)**	**You Pay**
	CROWN AND BRIDGE (includes local anesthesia)		
02510	Inlay, metallic, one surface	$ 68.00	All charges above scheduled allowance.
02710	Crown, resin (laboratory)	108.75	All charges above scheduled allowance.
02720	Crown, resin with high noble metal	178.00	All charges above scheduled allowance.
02740	Crown, porcelain with ceramic substrate	136.25	All charges above scheduled allowance.
02750	Crown, porcelain fused to high noble metal	178.00	All charges above scheduled allowance.
02752	Crown, porcelain fused to noble metal	178.00	All charges above scheduled allowance.
02790	Crown, full cast, high noble metal	149.50	All charges above scheduled allowance.
02810	Crown, ¾ cast metallic	102.25	All charges above scheduled allowance.
02920	Recement crown	27.50	All charges above scheduled allowance.
02952	Cast post and core, in addition to crown	68.00	All charges above scheduled allowance.
02954	Prefabricated post and core, in addition to crown	34.00	All charges above scheduled allowance.
02980	Crown repair	13.00	All charges above scheduled allowance.
	PONTICS (includes local anesthesia)		
06210	Cast high noble metal	$ 82.50	All charges above scheduled allowance.
06240	Porcelain fused to high noble metal	136.25	All charges above scheduled allowance.
	DENTURES (prosthetics)		
05110	Complete denture, maxillary (including necessary adjustments within 6 months)	$ 239.75	All charges above scheduled allowance.
05120	Complete denture, mandibular (including necessary adjustments within 6 months)	239.75	All charges above scheduled allowance.
05130	Immediate denture, maxillary	272.50	All charges above scheduled allowance.
05140	Immediate denture, mandibular	272.50	All charges above scheduled allowance.
05211	Partial denture, maxillary, resin base	217.75	All charges above scheduled allowance.
05510	Repair, complete denture, base	20.75	All charges above scheduled allowance.
05520	Repair, complete denture, repair or replace teeth (each tooth)	9.75	All charges above scheduled allowance.
05630	Repair, partial denture, repair or replace clasp	40.50	All charges above scheduled allowance.
05640	Repair, partial denture, repair or replace teeth (each tooth)	13.00	All charges above scheduled allowance.
05650	Add tooth, partial denture	34.00	All charges above scheduled allowance.
05660	Add clasp, partial denture	40.50	All charges above scheduled allowance.
05710	Rebase, complete denture, maxillary	68.00	All charges above scheduled allowance.

Dental benefits – continued on next page

Dental benefits *(continued)*

ADA Code	Service	We Pay (scheduled allowance)	You Pay
	ORAL SURGERY (includes local anesthesia)		
04210	Gingivectomy or gingivoplasty (per quadrant)	$ 102.50	All charges above scheduled allowance.
04260	Osseous surgery, including flap entry and closure (per quadrant)	137.50	All charges above scheduled allowance.
07110	Extraction of tooth — first tooth	15.00	All charges above scheduled allowance.
07120	Extraction of tooth — each additional tooth, same session	12.00	All charges above scheduled allowance.
07210	Surgical extraction of erupted tooth	23.00	All charges above scheduled allowance.
07285	Biopsy of oral hard tissue	34.00	All charges above scheduled allowance.
07310	Alveoloplasty in conjunction with extraction (per quadrant)	44.00	All charges above scheduled allowance.
07450	Removal of odontogenic cyst or tumor/lesion, up to 1.25 cm	66.00	All charges above scheduled allowance.
07510	Incision and drainage of abscess, intraoral soft tissue	13.00	All charges above scheduled allowance.
07960	Frenulectomy (frenectomy or frenotomy), separate procedure	61.50	All charges above scheduled allowance.
	MISCELLANEOUS SERVICES		
09110	Palliative treatment of dental pain, minor procedure	$ 7.50	All charges above scheduled allowance.
09220	General anesthesia — first 30 minutes	8.75	All charges above scheduled allowance.
09221	General anesthesia — each additional 15 minutes	4.38	All charges above scheduled allowance.
09310	Consultation by other than attending dentist	20.75	All charges above scheduled allowance.

Note: For services rendered due to accidental injury to sound natural teeth, see Section 5(d).

What is not covered

- *Charges related to orthodontia*
- *Oral hygiene instruction*
- *Denture replacements (if benefits were provided by this Plan within the last five years)*
- *Temporary dental services*
- *Dental implants or related surgical benefits*
- *Orthotics and other occlusal appliances used to treat temporomandibular joint dysfunction and/or sleep apnea*
- *Conservative treatment of temporomandibular joint dysfunction (TMJ)*

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

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

Non-FEHB Benefits Available to Plan Members

- **Vision One Eyecare Program** provides Plan enrollees and eligible family members the ability to obtain eye exams, frames, eyeglasses, and contact lenses at reduced prices from Vision One providers. For more information concerning the Vision One Eyecare Program or to locate a participating Vision One center near you, visit the Plan's web site (www.mhbp.com), or call 1-800-804-4384.
- **Laser Vision Correction Program** provides Plan enrollees and eligible family members the ability to take advantage of discounts on Lasik laser vision correction at LCA Vision Centers across the country. Lasik procedures are performed by board-certified ophthalmologists experienced in laser vision correction, using the latest equipment and technology in state-of-the-art facilities. To find out more about this program and learn of an LCA Vision Center near you, call 1-888-705-2020.
- **Miracle-Ear Hearing Program** provides Plan enrollees and eligible family members the ability to obtain free hearing tests and evaluations, free counseling, free check-up and cleaning of instruments, and a discount off of suggested retail prices of Miracle-Ear hearing aid products. Consult your Yellow Pages for a Miracle-Ear Center or Sears Hearing Aid Center, or simply call the Miracle-Ear Consumer Affairs Department at 1-800-456-6801 for the location nearest you.

Mail Handlers Benefit Plan enrollees who reside in the United States are all eligible for supplemental plans which are underwritten by CNA Insurance Companies, underwriter of the Mail Handlers Benefit Plan.

- **High Option Dental Supplement Plan** offers increased dental coverage to High Option enrollees and covered dependents. The Dental Supplement Plan will automatically increase benefits for covered diagnostic, preventive, and periodontal services by 60%; benefits for all other covered services will increase by 30%. Enrollees and covered dependents will also receive benefits for a second annual cleaning and exam. There is no deductible for this plan and no extra claim forms. For more information about the High Option Dental Supplement Plan, you may call 1-800-621-0839.
- **Standard Option Dental Program** provides dental benefits for Mail Handlers Benefit Plan Standard Option enrollees and their eligible family members. Like the regular MHBP High Option dental benefits, the Standard Option Dental Program pays benefits up to a scheduled allowance for most dental procedures up to a maximum annual benefit of $800 per person or $1,600 per family. And, like the regular High Option dental benefits, you can take advantage of Preferred Provider dentists to reduce your out-of-pocket costs even further. This plan has no deductible and you are always free to see any dentist you choose. For more information on this program, please call 1-800-621-0839.
- **Group Long Term Care Program** is designed to help people cope with the potentially devastating costs associated with long term care. The Mail Handlers Group Long Term Care Program lets enrollees choose the type of care they receive and where they receive it, either in a nursing home, assisted living facility, community setting, or at home. Long Term Care benefits are typically not provided by regular group health insurance, and Medicare benefits are limited, so coverage for long term care expenses can be an important financial decision. Complete information on the Mail Handlers Group Long Term Care Program, including a full explanation of rates and benefits, can be requested by visiting the MHBP web site (www.mhbp.com) or a kit can be requested by calling 1-800-522-0100. This program is underwritten by Continental Casualty Company, a CNA company. (Not available in MD)
- **Hospital Money Plan** provides daily cash benefits for hospitalization. Cash payments of up to $100 per day are paid directly to enrollees when they or a covered family member are hospitalized for any covered sickness or accident. If confinement is for intensive care, benefits of up to $200 per day are paid. The money is paid directly to the enrollee and may be spent in any way. For additional information concerning the Hospital Money Plan, you may call 1-800-621-0839.
- **Off-Work Accident Disability Plan** provides $150 a week when an enrollee is totally disabled by an off-work injury. The program also provides up to $25,000 for accidental death benefits. If the enrollee has children, up to $10,000 in educational benefits for each eligible child is provided if death occurs as a result of a covered injury. For more information about the Off-Work Accident Disability Plan, you may call 1-800-621-0839.
- **Short-Term Disability Income Protection** provides up to $500 or $1,000 per month to enrollees to replace lost income for a period of up to 12 or 24 months as a result of a disability due to a covered illness, injury, or complications of pregnancy. The benefit choice and period is up to the enrollee. All enrollees under the age of 60 are guaranteed acceptance in this plan as long as they actively work at least 30 hours a week and have not been hospitalized in the last six months. For more information about this program, call 1-800-621-0839.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as covered, we will not provide benefits for it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services and supplies for which there would be no charge if the covered individual had no health insurance coverage;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction or sexual inadequacy, penile prosthesis;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services and supplies furnished without charge while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as the result of an act of war within the Unites States, its territories or possessions, or (2) during combat;
- Services and supplies furnished by household members or immediate relatives, such as spouse, parents, grandparents, children, brothers or sisters by blood, marriage or adoption;
- Services and supplies furnished or billed by a non-covered facility, except that medically necessary prescription drugs are covered;
- Services, drugs and supplies associated with care that is not covered, though they may be covered otherwise (e.g., Inpatient Hospital Benefits are not payable for non-covered cosmetic surgery);
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copayment or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 14), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge) (see page 15), or State premium taxes however applied;
- Services, drugs and supplies for weight control or treatment of obesity, except surgery for documented morbid obesity;
- Educational, recreational or milieu therapy, whether in or out of the hospital;
- Services and supplies for cosmetic purposes, except as provided under Surgical Benefits/Reconstructive Surgery;
- Biofeedback;
- Cardiac rehabilitation;
- Eyeglasses, contact lenses and hearing aids, except as provided under Section 5(a);
- Orthotics and appliances used to treat temporomandibular joint dysfunction and/or sleep apnea;
- Custodial care (see definition) or domiciliary care;
- Travel, even if prescribed by a doctor, except as provided under the Ambulance Benefit;
- Handling Charges/Administrative Charges or late charges, including interest, billed by providers of care; and
- Services and/or supplies not listed as covered in this brochure.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 1-800-410-7778, or visit our web site at www.mhbp.com

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. All claims should be completed in ink or type that is readable by an optic scanner. For claims questions and assistance, call us at 1-800-410-7778.

When you must file a claim — such as for overseas claims or when another group health plan is primary — submit it on the HCFA-1500 or a claim form that includes the information shown below. Claims should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name, address and provider or employer tax identification of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

In addition:

- You must send a copy of the explanation of benefits (EOB) from any primary payer, such as the Medicare Summary Notice (MSN), with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse and must include nursing notes.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the patient's attending physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for overseas (foreign) services should include an English translation. The Plan applies the exchange rate for the date the services were rendered.
- All foreign claim payments will be made directly to the enrollee except for services rendered to beneficiaries of the Department of Defense third party collection program.
- Canceled checks, cash register receipts, or balance due statements are not acceptable.

After completing a claim form and attaching proper documentation, send medical and dental claims to:

Mail Handlers Benefit Plan
P.O. Box 45118
Jacksonville, FL 32232-5118

- Claims for prescription drugs and supplies that are not ordered through the Mail Service Prescription Drug Program or purchased from and filed with an AdvancePCS network pharmacy must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.

After completing a claim form and attaching proper documentation send prescription claims to:

AdvancePCS
MHBP Claims
P.O. Box 52151
Phoenix, AZ 85072-2151

Note: Do not include any medical or dental claims with your claims for drug benefits.

If all the required information is not included on the claim, the claim may be delayed or denied.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

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. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Direct payment to hospital or provider of care

Claims for inhospital confinements that are submitted by the hospital will be paid directly to the hospital (with the exception of foreign claims). You may authorize direct payment to any other provider of care by signing the assignment of benefits section on the claim form, or by using the assignment form furnished by the provider of care. The provider of care's Tax Identification Number must accompany the claim. The Plan reserves the right to make payment directly to you, and to decline to honor the assignment of payment of any health benefits claim to any person or party.

Claims submitted by PPO hospitals and medical providers will be paid directly to the hospital or provider.

Note: Benefits for services provided at Department of Defense, Veterans Administration or Indian Health Service facilities will be paid directly to the facility.

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.

The Plan, its medical staff and/or an independent medical review, determines whether services, supplies and charges meet the coverage requirements of the Plan (subject to the disputed claims procedure described in Section 8. The disputed claims process). We are entitled to obtain medical or other information — including an independent medical examination — that we feel is necessary to determine whether a service or supply is covered.

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.

Step	Description

1 Ask us in writing to reconsider our initial decision. You must:

(a) Write to us within 6 months from the date of our decision; and

(b) Send your request to us at: Mail Handlers Benefit Plan, P.O. Box 45118, Jacksonville, FL 32232-5118; 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 health care provider to give you the care); or

(b) Write to you and maintain our denial — go to step 4; or

(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3.

3 You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, 1900 E Street NW, Washington, D.C. 20415-3620.

Send OPM the following information:

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

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must 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.

The disputed claims process *(continued)*

Step	Description
5	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.
6	If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, 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 1-800-410-7778 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 can call OPM's Health Benefits Contracts Division 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating Benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays medical 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. The combined payment from both plans may not equal the entire amount billed by the provider.

The provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given to this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

• What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) 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.

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

• 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. Some things are not covered under Original Medicare, like prescription drugs.

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.

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 Medicare.

- When we are the primary payer, we process the claim first.
- When the Original Medicare Plan is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will consider the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-410-7778 or check www.mhbp.com.

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

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

We limit our payment to an amount that supplements the benefits that Medicare would pay under Part A (Hospital insurance) and Part B (Medical Insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services both we and Medicare Part B cover depend on whether your physician accepts Medicare assignment for the claim.

When Medicare Part A is primary, all or part of your Plan deductibles and coinsurance will be waived as indicated below:

- When Medicare Part A is primary, the Plan will waive applicable per-admission copayments and coinsurance for Inpatient Hospital Benefits and Inpatient Mental Conditions/Substance Abuse Benefits.
- When Medicare Part B is primary, the Plan will waive applicable deductibles, copayments and coinsurance for surgical and medical services billed by physicians, durable medical equipment, orthopedic and prosthetic appliances and ambulance services.
- When Medicare Part B is primary, the Plan will waive the calendar year deductible (but not the coinsurance) for nursing benefits and outpatient mental conditions and substance abuse benefits.
- When Medicare Parts A and B are primary, the Plan will waive the deductible for prescription drugs purchased through the mail order prescription drug program.

Note: The Plan will not waive the deductible and coinsurance for retail prescription drugs.

- **Private Contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment. We will not waive any deductibles, coinsurance or copayments when paying these claims.

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart

A. When either you – or your covered spouse – are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when… a) The position is excluded from FEHB or,	✓	
b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)		✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you — or a covered family member — have Medicare based on End Stage Renal Disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan – a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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

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

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both parts of Medicare, you can still be covered under the FEHB program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage. If you are enrolled in the Uniformed Services Family Health Plan, the Mail Handlers Benefit Plan is primary.

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.

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

If you or any covered member of your family suffer injuries in an accident, or become ill, because of the actions of another person, and you thereafter receive compensation, either from that person or from your own or other insurance, for the injuries or illness, you will be required to reimburse the Plan for any services and supplies the Plan paid for out of the compensation you receive. This is known as the Plan's right of reimbursement, and is also sometimes referred to as subrogation. You will have this obligation to reimburse the Plan even if the compensation you receive is not sufficient to compensate you fully for all of the damages which resulted from the accident or illness. In other words, the Plan is entitled to be reimbursed for all expenditures it has made on your behalf even if you are not "made whole" for all of your damages by the compensation you receive. The Plan's right to reimbursement is also not subject to reduction for attorney's fees under the "common fund" doctrine without the Plan's written consent. The Plan enforces this right of reimbursement by asserting a lien against any and all compensation you receive, whether by court order or out-of-court settlement. You must cooperate with the Plan in its enforcement of this right of reimbursement by telling the Plan whenever you or a covered member of your family has filed a claim for compensation resulting from an accident or illness. You must also accept the Plan's lien for the full amount of the benefits it has paid; you must agree to assign any proceeds from third party claims or your own insurance to the Plan when asked to do so; and you must sign a Reimbursement Agreement for this purpose when asked by the Plan to do so. We will not pay benefits until this agreement is signed. The Plan's right to full reimbursement applies even if the Plan has paid benefits before we know of the accident or illness, and before we have asked you to sign a Reimbursement Agreement. Unless the Plan agrees in writing to accept less than 100% of the Plan's lien amount, the Plan is entitled to be reimbursed for all the benefits it has paid on account of the accident or illness. If you would like more information about the subrogation process and how it works, please call the Plan's Third Party Recovery Services unit at 301-610-0919.

Section 10. Definitions of terms we use in this brochure

Admission

The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as the same day.

Assignment

An authorization by an enrollee or spouse for the Plan to issue payment of benefits directly to the provider. The Plan reserves the right to pay the member directly for all covered services.

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. You may also be responsible for additional amounts. See page 11.

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes, and other conditions that the Plan may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intraoral structures supporting the teeth.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Covered services

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

Custodial care

The Plan determines what services are custodial in nature. For instance, the following are considered custodial services:

- Help in walking; getting in and out of bed; bathing; eating (including help with tube feeding or gastrostomy) exercising and dressing
- Homemaking services such as making meals or special diets
- Moving the patient
- Acting as companion or sitter
- Supervising medication when it can be self administered; or
- Services that anyone with minimal instruction can do, such as taking a temperature, recording pulse, respiration or administration and monitoring of feeding systems.

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 11.

Experimental or investigational services

A drug, device, or biological product is Experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is Experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, biological product, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, biological product, or medical treatment or procedure.

If you wish additional information concerning the experimental/investigational determination process, please contact the Plan.

Group health coverage

Health care 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 health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.

Hospice care program

A formal program directed by a doctor to help care for a terminally ill person. The services may be provided through either a centrally-administered, medically-directed, and nurse-coordinated program that provides primarily home care services 24 hours a day, seven days a week by a hospice team that reduces or abates mental and physical distress and meets the special stresses of a terminal illness, dying and bereavement, or through confinement in a hospice care program. The hospice team must include a doctor and a nurse (R.N.) and also may include a social worker, clergyman/counselor, volunteer, clinical psychologist, physical therapist, or occupational therapist.

Medical necessity

Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that the Plan determines:

1) are appropriate to diagnose or treat the patient's condition, illness, or injury;
2) are consistent with standards of good medical practice in the United States;
3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4) are not a part of or associated with the scholastic education or vocational training of the patient; and,
5) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Morbid obesity

A condition in which an individual weighs 100 pounds or 100% over his or her normal weight (in accordance with current underwriting standards). Eligible members must be age 18 or over.

Orthopedic appliance

Any fitted external device used to support, align, prevent, or correct deformities, or to restore or improve function.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

PPO allowance: an amount that we negotiate with each provider or provider group who participates in our network. For these PPO allowances, the PPO provider has agreed to accept the negotiated reduction and you are not responsible for the discounted amount. In these instances, the benefit we pay plus any applicable deductible, copayment or coinsurance you are responsible for, equals payment in full.

Managed In-Network allowance: a negotiated amount the mental health/substance abuse provider has agreed to accept as the negotiated reduction and you are not responsible for the discounted amount. In these instances, the benefit we pay plus any applicable deductible, copayment or coinsurance you are responsible for, equals payment in full.

Non-PPO allowance: the amount the Plan will consider for services provided by non-PPO or non-Managed In-Network providers. Non-PPO allowances are determined as follows:

If you live in an area that has a fully developed PPO network (one in which you have adequate access to a network provider), but you do not use a PPO network provider the Plan's allowance will be reduced to a rate that the Plan would have paid had you used a PPO provider. This non-PPO allowance is based upon a fee schedule that represents an average of the PPO fee schedules for a particular service in a particular geographic area. In industry terms, this is a called a "blended" fee schedule.

Note: For those members who do not have adequate access to a network provider (in terms of distance from where you live to a network provider) or those members receiving emergency care, the Plan's non-PPO allowance will be based on the reasonable and customary charge (as described below), not the "blended" fee schedule.

If you live in an area that does not have a fully developed network, and use a non-PPO provider, the non-PPO allowance is the reasonable and customary allowance for your medical or mental health/substance abuse services based on the reasonable and customary charge. This is generally the lesser of either (a) the usual charge made by the provider for the service or supply in the absence of insurance or, (b) the charge that the Plan determines to be in the 80th percentile of the prevailing charges made for the service or supply in the geographic area in which it is furnished. The prevailing charge data is collected by the Plan's underwriter. For certain services, exceptions to the general method of determining reasonable and customary may exist.

If you receive services from a MultiPlan participating provider, the Plan's allowance will be the amount that the provider has negotiated and agreed to accept for the services and or supplies. Benefits will be paid at non-PPO benefit levels, subject to the applicable deductibles and copayments.

For more information, see *Differences between our allowance and the bill* in Section 4.

Prosthetic appliance An artificial substitute for a missing body part such as an arm, eye, or leg. This appliance may be used for a functional or cosmetic reason, or both.

Scooters A power-operated vehicle (chair or cart) with a base that may extend beyond the edge of the seat, a tiller-type control mechanism which is usually center mounted and an adjustable seat that may or may not swivel.

Us/We Us and we refer to the Mail Handlers Benefit Plan.

Vested rights An enrollee does not have a vested right to the benefits in this brochure in 2003 or later years and does not have a right to benefits available prior to 2002 unless those benefits are in this brochure.

You You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB program

See www.opm.gov/insur. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans* brochures for other plans, and other materials you need to make an informed decision about:

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you 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. 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.

Your medical and claims records are confidential

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

- OPM, this Plan, and subcontractors when they administer this contract;
- In an effort to improve healthcare quality and patient safety, the Plan may disclose information about a member's prescription drug use, including the names of the doctors who prescribed the drugs to any of your treating physician or any pharmacy who is dispensing the drug;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

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

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

- **Spouse equity coverage**

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

- **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 Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insur.

- **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 FEHBP web site (http://www.opm.gov/insure/health), and 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 have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long-term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan, just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planning.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can exhaust your savings. *Long term care insurance can protect your savings*.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "Not covered" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aid to help get you in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received.
  Long term care insurance can provide choices of care and preserve your independence.

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA area
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2001 Open Season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during Open Season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

Temporary continuation of coverage (TCC) eligibility

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

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

Summary of Standard Option benefits for the Mail Handlers Benefit Plan – 2002

- **Do not rely on this chart alone.** All benefits 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.
- Below, an asterisk (*) means the item is subject to the $250 Calendar Year medical deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page(s)
Medical services provided by physicians: • Diagnostic and treatment services provided in the office • Inpatient hospital visits • Preventive care (see specific services) • Maternity services • Treatment therapy, rehabilitative therapies, chiropractic, alternative therapies (subject to applicable calendar year maximums)	PPO: $15 copayment per office visit; $5 copayment per allergy injection; 10%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services Non-PPO: 30% of the Plan's allowance per office visit; 30%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services	17–31
Services provided by a hospital:		
• Inpatient	PPO: $150 per admission Non-PPO: $300 per admission	39-41
• Outpatient		
— surgical facility	PPO: Nothing after the calendar year deductible Non-PPO: 30%* of the Plan's allowance	42
— hemodialysis, chemotherapy, radiation treatment	PPO: 10%* of the Plan's allowance Non-PPO: 30%* of the Plan's allowance	24
Emergency benefits:		
• Accidental injury	Regular benefits	44-45
• Medical emergency	Regular benefits	45
Mental health and substance abuse treatment Note: This benefit has a separate calendar year deductible.	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	46-48
Prescription drugs	After $600 per person ($1,200 per family) calendar year prescription deductible: Network Retail electronic: 30% of AdvancePCS charges Network Retail paper: 50% of AdvancePCS charges Non-Network Retail: 50% of AdvancePCS charges Mail Order: $10 copayment per generic prescription; $40 per preferred brand; $55 per non-preferred brand	49-51
Dental Care	No benefit	N/A
Special features: Flexible Benefits Option; Worldwide Assistance		52
Protection against catastrophic costs (your out-of-pocket maximum) There is a separate out-of-pocket maximum for Managed In-Network mental health and substance abuse treatment services that must be met for this benefit to apply. This benefit does not apply to mental health and substance abuse treatment services provided by out-of-network providers.	Nothing after your covered expenses total $4,000 per year for PPO providers/facilities. When you use a combination of PPO and non-PPO providers, your covered out-of-pocket expenses will not exceed $4,000. Some costs do not count toward this protection.	12

Summary of High Option benefits for the Mail Handlers Benefit Plan – 2002

- **Do not rely on this chart alone**. All benefits 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.
- Below, an asterisk (*) means the item is subject to the $200 Calendar Year medical deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page(s)
Medical services provided by physicians: • Diagnostic and treatment services provided in the office • Inpatient hospital visits • Preventive care (see specific services) • Maternity services • Treatment therapy, rehabilitative therapies, chiropractic, alternative therapies (subject to applicable calendar year maximums)	PPO: $15 copayment per office visit; $5 copayment per allergy injection; 10%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services Non-PPO: 30% of the Plan's allowance per office visit; 30%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services	17-31
Services provided by a hospital:		
• Inpatient	PPO: Nothing Non-PPO: $250 per admission	39-41
• Outpatient		
— surgical facility	PPO: Nothing after the calendar year deductible Non-PPO: 30%* of the Plan's allowance	42
— hemodialysis, chemotherapy, radiation treatment	PPO: 10%* of the Plan's allowance Non-PPO: 30%* of the Plan's allowance	24
Emergency benefits:		
• Accidental injury	Regular benefits	44-45
• Medical emergency	Regular benefits	45
Mental health and substance abuse treatment Note: This benefit has a separate calendar year deductible.	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	46-48
Prescription drugs	After $250 per person ($500 per family) calendar year prescription deductible: Network Retail electronic: 25% of AdvancePCS charges Network Retail paper: 50% of AdvancePCS charges Non-Network Retail: 50% of AdvancePCS charges Mail Order: $10 copayment per generic prescription; $30 per preferred brand; $45 per non-preferred brand	49-51
Dental Care	All charges above amount stated in dental schedule	53-56
Special features: Flexible Benefits Option; Worldwide Assistance		52
Protection against catastrophic costs (your out-of-pocket maximum) There is a separate out-of-pocket maximum for Managed In-Network mental health and substance abuse treatment services that must be met for this benefit to apply. This benefit does not apply to mental health and substance abuse treatment services provided by out-of-network providers.	Nothing after your covered expenses total $2,500 per year for PPO providers/facilities. When you use a combination of PPO and non-PPO providers, your covered out-of-pocket expenses will not exceed $4,000. Some costs do not count toward this protection.	12

2002 Rate Information for the Mail Handlers Benefit Plan

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

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

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

		Non-Postal Premium				***Postal Premium***	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	451	$97.86	$55.08	$212.03	$119.34	$115.52	$37.42
High Option Self and Family	452	$223.41	$99.20	$484.06	$214.93	$263.75	$58.86
Standard Option Self Only	454	$76.96	$25.65	$166.74	$55.58	$91.07	$11.54
Standard Option Self and Family	455	$167.04	$55.68	$361.92	$120.64	$197.66	$25.06