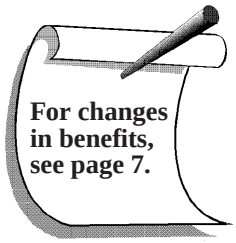
PBP Health Plan

http://www.postmasters.org/pbp.asp

People Before Profit

2002

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



Sponsored and administered by: The National League of Postmasters

Who may enroll in this Plan: All Federal Employees and annuitants who are eligible to enroll in the Federal Employee Health Benefits Program and who are or become, members or League Benefit Members of the National League of Postmasters of the United States.

To become a member or League Benefit Member: To be eligible for membership in the League, you must be an active or retired employee of the Federal Government or the United States Postal Service

If you are a non-postal employee/annuitant, you will automatically become a League Benefit member of the National League of Postmasters upon enrollment in the PBP Health Plan.

Annuitants (retirees) may enroll in this Plan.

Membership dues: $35 per year for League Benefit membership. The National League of Postmasters will bill new League Benefit members for the annual dues when it receives notice of enrollment. The National League of Postmasters will also bill continuing League Benefit members for the annual membership. Postmaster members must pay dues based on level of office. Dues are paid by payroll deduction or annually at the option of the Postmaster. Continuing Postmaster members are billed annually for membership dues.

Enrollment codes for this Plan:

361 High Option - Self Only
362 High Option - Self and Family
364 Standard Option - Self Only
365 Standard Option - Self and Family

Authorized for distribution by the:

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT

RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

Table of Contents

Introduction

PBP Health Plan
1019 N. Royal Street
Alexandria, Virginia 22314-1596

This brochure describes the benefits of the PBP Health Plan under our contract (CS 1071) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. 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 changes are summarized on page 7. 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. For instance, “you” means the enrollee or family member; "we" means PBP Health 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 us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov.

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 800/544-7111 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, DC 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 the person tries to obtain services for someone who is not an eligible family member, or are no longer enrolled in the Plan and tries 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.

We also have 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 and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB website, www.opm.gov/insure. 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.

How we pay providers

We make benefits payments to you or your provider, on your behalf. The benefit payment is the same in both cases. When we pay providers, our payment is based on the services they provide to you. We make no other payments to providers. Our payment policy does not include provider bonuses or financial incentives. Our payment policy does not encourage your provider to give any more or less medical care than your physical or mental condition requires.

Your Rights

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

- Compliance or licensing requirements: None apply
- Years in existence: 41
- Profit status: Non-profit

If you want more information about us, call 800/544-7111, or write to PBP Health Plan, 1019 North Royal Street, Alexandria, Virginia 22314-1596. You may also contact us by fax at 703/683-2937 or visit our website at www.postmasters.org/pbp.asp.

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 medically underserved areas: Georgia, Montana, North Dakota and Texas. Louisiana is no longer a medically underserved area. (Section 3.)

Changes to this Plan

Both Options

- We clarified the brochure to better explain that the non-PPO benefits are the standard benefits of this Plan, that PPO benefits apply only when you use a PPO provider, and that when no PPO provider is available, non-PPO benefits apply.
- We clarified the Family planning and Infertility benefits by providing more examples of covered and not covered benefits. (Section 5(a))
- We clarified Surgical procedures to show that we cover a comprehensive range of services, such as operative procedures. (Section 5(b))
- We provide up to $2,000.00 per person per year for any combination of chiropractic services, physical therapy, occupational therapy, speech therapy and therapeutic acupuncture. Previously, many of these services were subject to individual limits.
- We now cover hepatitis B vaccinations for certain adults. (Section 5(a))
- We now cover one colonoscopy screening every two years for patients age 40 and older. (Section 5(a))
- We now cover one barium enema screening every two years for patients age 40 and older. (Section 5(a))
- We now cover routine screening for chlamydial infection. (Section 5(a))
- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We clarified the brochure to show why we think you should use generic drugs whenever possible. We moved other language around within the Prescription drugs section but didn't change its meaning. (Section 5(f))
- We clarified the Medicare Primary Payer Chart to explain how we coordinate benefits for former spouses. (Section 9)
- We clarified other language about coordinating benefits with Medicare. (Section 9)

Standard Option

- Your share of the non-Postal premium will decrease by 12.0% for Self Only or 15.6% for Self and Family.
- We now cover mail order prescription drugs for up to a 90-day supply with no deductible. You pay a $15 copayment for generic drugs, a $30 copayment for formulary drug, or the greater of a $40 copayment or 20% of the drug's cost for non-formulary drug. If you have Medicare coverage, you pay a $7 copayment for generic drugs, a $15 copayment for formulary drug, or the greater of a $25 copayment or 20% of the drug's cost for non-formulary drug.

High Option

- Your share of the non-Postal premium will decrease by 6.5% for Self Only or 7.5% for Self and Family.
- We now cover mail order prescription drugs for up to a 90-day supply with no deductible. You pay a $10 copayment for generic drugs, a $25 copayment for formulary drug, or the greater of a $40 copayment or 20% of the drug's cost for non-formulary drug. If you have Medicare coverage, you pay a $5 copayment for generic drugs, a $12 copayment for formulary drug, or the greater of a $25 copayment or 20% of the drug's cost for non-formulary drug.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card and a prescription drug card when you enroll. You should carry your ID card and your prescription drug card with you at all times. You must show your ID card whenever you receive services from a Plan provider. You must show your prescription drug card to obtain 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 800/544-7111.

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 services within the scope of their license or certification:

A licensed doctor of medicine(M.D.) or a licensed doctor of osteopathy (D.O.). Other covered providers include: a licensed doctor of podiatry (D.P.M.); a licensed dentist (D.D.S or D.M.D.); licensed chiropractor (D.C.); licensed or registered physical, occupational and speech therapists (R.P.T., R.S.T., R.O.T. and S.P.). Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, Certified Registered Nurse Anesthetist (C.R.N.A.), nurse practitioner/clinical specialist and 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:

- Free-standing ambulatory facility
  An out-of-hospital facility such as medical, cancer, dialysis, or surgical center or clinic, and licensed outpatient facilities accredited by the Joint Commission on Accreditation of Healthcare Organization for treatment of substance abuse.

- Hospice
  A facility whose staff must include a doctor and registered nurse (R.N.) and may include social worker, clergymen/counselor, volunteers, clinical psychologists and physical or occupational therapists who are able to provide care 24 hours a day.

- Hospital
  (1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organization, or

  (2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors, with 24-hour-a-day nursing service and that is primarily engaged in providing for sick and injured inpatients: general care and treatment through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control, or specialized care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those services.

- Rehabilitation facilities
  An institution that: (1) meets the "hospital" definition as stated; or (2) provides a program for the treatment of alcohol or drug abuse and meets one of the following requirements: (a) is affiliated with a hospital under a contractual agreement with an established patient referral system; (b) is licensed, certified or approved as an alcohol or drug abuse rehabilitation facility by the State; or is accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations.

- Skilled nursing facility
  An institution that (1) is operated pursuant to law and primarily engaged in providing the following services for patients recovering from an illness or injury: room, board and 24-hour-a-day nursing service by professional nurses; (2) is under the fulltime supervision of a doctor or registered nurse (R.N); (3) maintains adequate medical records; and (4) has the services of a doctor available under an established agreement for 24 hours a day, if not supervised by a doctor.

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 service department immediately at 800/544-7111.

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

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

These provisions apply only to the benefits of the hospitalized person.

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. If the stay is not medically necessary, we will not pay any benefits.

How to precertify an admission:

- You, your representative, your doctor, or your hospital must call us at 1-866-218-8317 at least 48 hours before an admission.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- 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 and phone number of admitting doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.

- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

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 your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

If your hospital stay needs to be 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 did not get the additional days precertified, then:
  - for the part of the admission that was medically necessary, we will pay inpatient benefits, but
  - for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient 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 inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.
- If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any 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.

• Other services

Some services require a precertification or prior authorization.

- Durable medical equipment - We must pre-approve the purchase of any covered durable medical equipment in excess of $300. A letter of medical necessity must be submitted to the Plan.

- Network mental health and substance abuse - We must pre-approve a treatment plan for covered network benefits. Advise your provider to fax a written treatment plan, for review and approval, to the attention of: PBP Mental Health Coordinator at 703-836-8937.

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 under Standard Option you pay a copayment of $10 per visit and when you go to a hospital, you pay $250 per admission

•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 them. Copayments do not count toward any deductible.

- The calendar year deductible is $250 (PPO) or $500 (Non-PPO) per person under Standard Option and $200 (PPO) or $400 (Non-PPO) per person under High Option. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $500 (PPO) or $1000 (Non-PPO) under Standard Option and $400 (PPO) or $800 (Non-PPO) under High Option.

- We also have separate deductibles for:
  - Prescription drugs - $100 for network retail pharmacies or $150 for non-network retail pharmacies per person, per year for both High Option and Standard Option
  - Dental - $30 per person per year for High Option. There is no Standard Option deductible for Dental Benefits.
  - The mental conditions/substance abuse – $250 (PPO) or $300 (Non-PPO) per person under Standard Option and $200 (PPO) or $275 (Non-PPO) per person under High Option. Under a family enrollment, the deductible is satisfied for all family members when the combined covered mental conditions/substance abuse expenses for the year reach $500 (PPO) or $600 (Non-PPO) under Standard Option and $400 (PPO) or $550 (Non-PPO) under High Option.

Note: If you change plans during opens 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: Under High Option you pay 10% of our allowance for office visits to a network provider

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 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 and coinsurance or copayment. Here is an example about coinsurance: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just -- 10% of our $100 allowance ($10) under High Option. 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 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 20% of our $100 allowance ($20) under High Option. 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.

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	90% of our allowance: 90	80% of our allowance: 80
You owe: Coinsurance	10% of our allowance: 10	20% of our allowance: 20
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	$10	$70

Your out-of-pocket maximum for coinsurance

For those services with coinsurance, other than prescription drug services, we pay **100%** of the Plan allowance for the remainder of the calendar year after your out-of-pocket expenses for the services shown below for the calendar year exceed $5,000 ($3,500 PPO) per person per year or $5,500 ($4,000 PPO) per family under **Standard Option** and $3,500 ($3,000 PPO) per person per year or $4,000 ($3,500 PPO) per family under **High Option.**

Out-of-pocket expenses for the purposes of this benefit are:

Standard Option

- The 30% you pay for hospital room and board, or 10% you pay for hospital room and board if using a PPO;
- The 30% you pay for medical services or 10% if using a PPO;
- The 30% you pay for Emergency Room Treatment or 10% if using a PPO;
- The 30% you pay for hospital services or 10% if using a PPO;
- The 30% you pay for surgical services or 10% if using a PPO; and
- The 30% you pay for durable medical equipment.

High Option

- The 25% you pay for hospital room and board, or the 10% you pay for hospital room and board if using a PPO;
- The 20% you pay for medical services or 10% if using a PPO;
- The 20% you pay for Emergency Room Treatment or 10% if using a PPO;
- The 25% you pay for hospital services or 10% if using a PPO;
- The 20% you pay for surgical services or 10% if using a PPO; and
- The 20% you pay for durable medical equipment

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

- Copayments;
- Prescription drug expenses;
- Expenses in excess of the Plan allowances or maximum benefit limitations;
- Expenses for mental conditions / substance abuse (See Section 5(e));
- Expenses for dental care; and
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see page 10).
- Deductibles

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.

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** as 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 applicable deductibles, coinsurance 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.

- If your physician accepts Medicare assignment, then you pay nothing for covered charges.

- If your physician does not accept Medicare assignment, then you pay the difference between our payment combined with Medicare's payment and the charge.

Note: The physician who does not accept Medicare assignment 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 their 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 86 and 87 for a benefit 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 claim forms, claims filing advice, or more information about our benefits, contact us at 800/544-7111 or at our website at www.postmasters.org/pbp.asp

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

IMPORTANT

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 (PPO) or $500 (non-PPO) per person or $500 (PPO) or $1000 (non-PPO) per family under Standard Option and $200 (PPO) or $400 (non-PPO) per person or $400 (PPO) or $800 (non-PPO) per family under the 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.
- The non-PPO benefits are the standard 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.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…	
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**You pay - Standard Option**	**You pay - High Option**
Professional services of physicians • In physician's office, when billed charges include an office visit, labs, x-rays or surgeries rendered by the physician during the visit • At home Note: These services do not include services billed by independent laboratory or x-ray facilities or services billed by providers other than physicians	PPO: $10 copayment (No deductible) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount.

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 • In an urgent care center • During a hospital stay • In a skilled nursing facility • Medical consultations • Second surgical opinion • Cardiac rehabilitation • Initial inpatient examination of a newborn child covered under a family enrollment	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount.
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 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 allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount.

Preventive care, adult	You pay – Standard Option	You pay - High Option
Routine screenings, limited to: • Hepatitis vaccinations, when pre-approved by the Plan, for high-risk individuals. Call us at 1-800-544-7111 for information about pre-approval • One colonoscopy every two years, age 40 and older • One barium enema every two years, age 40 and older • Total Blood Cholesterol – once every three years • Physical exams- (including a complete history and workup) once every two years, age 13 through 39; and once every year, age 40 and above. • Chlamydial infection for sexually active females under 25 • Colorectal Cancer Screening, including – One annual fecal occult blood test, age 40 and older.	PPO: 10% of the Plan allowance Non -PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount
– Sigmoidoscopy, screening – One every five years starting at age 50	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO:10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount.
Prostate Specific Antigen (PSA test) – One annually for men age 40 and older	PPO:10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult – Continued on next page

Preventive care, adult – *continued*	**You pay - Standard Option**	**You pay-High Option**
Routine pap test – One annually for women age 18 and older. Note: The office visit is covered if pap test is received on the same day; see Diagnosis and Treatment, above.	PPO: 10% of the Plan allowance. Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO:10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	PPO:10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount.
Routine immunizations, limited to: • Influenza/Pneumococcal vaccine-One annually, age 65 and over	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)
Not covered: Physical exams for school, sports, employment or travel	*All charges.*	*All charges*
Preventive care, children		
• Childhood immunizations recommended by the American Academy of Pediatrics Note: Covered for dependent children under age 22	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)

Preventive care, children – Continued on next page

Preventive care, children - *continued*	**You pay - Standard Option**	**You pay - High Option**
• For well-child care charges for routine examinations (including blood lead level screenings and routine office visits, lab, and x-rays), for children through age 12.	PPO: Any difference between our $125 calendar year allowance and the billed amount. (No deductible). Non-PPO: Any difference between our $125 calendar year allowance and the billed amount. (No deductible).	PPO: Any difference between the $150 calendar year allowance and the billed amount. (No deductible). Non-PPO: Any difference between the $150 calendar year allowance and the billed amount. (No deductible).
Maternity care		
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery. See *Section 3, How you get care*, for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will 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.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount.

Maternity care –Continued on next page

Maternity care – c*ontinued*	**You pay - Standard Option**	**You pay - High Option**
• Stand-by doctor charges will be covered only if medically necessary treatment is actually rendered to the child by the doctor. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*	*All Charges*
Family planning		
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount. (No deductible)
• Injectable contraceptive drugs (Such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit. Section 5(f).	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered: reversal of voluntary surgical sterilization, genetic counseling	*All charges*	*All Charges*
Infertility services		
Diagnosis and treatment of infertility, except as shown in Not covered.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount

Infertility services – Continued on next page

Infertility services – *continued*	**You pay - Standard Option**	**You pay–High Option**
Not covered: • Infertility services after voluntary sterilization • *Assisted reproductive technology (ART) procedures, such as:* – *artificial insemination* – *in vitro fertilization* – *embryo transfer and (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		
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	PPO:10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount
Treatment therapies		
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 36. • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount

Treatment therapies – Continued on next page

Treatment therapies – *continued*	**You pay - Standard Option**	**You pay- High Option**
Note: – We only cover GHT when we preauthorize the treatment. To obtain preauthorization, you may call our customer service department at 800/544-7111 and have your physician submit the complete medical information to the Plan. If we determine GHT is not medically necessary we will not preauthorize the GHT or any related services and supplies. • Respiratory and inhalation therapies	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: *Chelation therapy, except for acute arsenic, gold, lead or mercury poisoning*	*All charges*	*All charges*
Physical and occupational therapies		
Covered under Alternative treatment		
Speech therapy		
Covered under Alternative treatment		
Hearing services (testing, treatment, and supplies)		
Hearing aids, including exams, tests and adjustments to hearing devices when necessitated by accidental injury or surgery Note: Must be obtained within 120 days of the surgery or injury	PPO: Same as non-PPO Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Same as non-PPO Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *routine hearing testing* • *hearing aids, testing and examinations and batteries for them, except for accidental injury or surgery*	*All charges.*	*All charges*

Vision services (testing, treatment, and supplies)	You pay - Standard Option	You pay- High Option
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts).	PPO: Same as non-PPO Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Same as non-PPO Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them except as noted as covered* • *Eye exercises and orthoptics (visual training)* • *Radial keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Removal or treatment of corns, calluses, free edge of toenails, and foot subluxations* • *Foot orthotics* • *Arch supports* • *Orthopedic and corrective shoes* • *Heel pads and heel cups*	*All charges*	*All charges*

Orthopedic and prosthetic devices	You pay - Standard Option	You pay- High Option
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device, and 5 (c) for inpatient and outpatient hospital charges.	PPO: Same as non-PPO Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: Same as non-PPO Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges.*	*All charges.*

Durable medical equipment (DME)	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. Under this benefit, we also cover: • Hospital beds; • Wheelchairs; • Crutches; and • Walkers. Note: Call us at 800/544-7111 for information on how to get pre-approval. Note: A purchase of durable medical equipment in excess of $300 must be supported by a letter of medical necessity and pre-approved by the Plan to be covered.	PPO: Same as non-PPO (No deductible) Non-PPO: $100 copayment per device and 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)	PPO: Same as non-PPO (No deductible) Non-PPO: $100 copayment per device and 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Sun or heat lamps; heating pads;* • *Air conditioners, purifiers and humidifiers;* • *Exercise, safety, computer, communication and convenience equipment;* • *Whirlpools, saunas and similar household items*	*All charges*	*All charges*

Durable medical equipment (DME) – Continued on next page

Durable medical equipment (DME) – *continued*	**You pay - Standard Option**	**You pay - High Option**
Not covered: • *Stair glides, ramps, liftchairs, elevators and other modifications or alterations to vehicles or households;*	*All charges*	*All charges*
Home health services		
Nursing services and home health care when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • A home health aide, that is part of a home health care plan after discharge from covered hospital confinement provides the services • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed.	PPO: Same as non-PPO Non-PPO: 30% of the Plan allowance and any difference between the $10,000 per person, per year, maximum Plan payment and the billed amount	PPO: Same as non-PPO Non-PPO: 20% of the Plan allowance and any difference between the $10,000 per person, per year, maximum Plan payment and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;* • *Private duty nursing care while confined in a hospital*	*All charges.*	*All charges*

Chiropractic	You pay - Standard Option	You pay - High Option
Covered under Alternative treatment		
Alternative treatments		
Acupuncture by a doctor of medicine, osteopathy, or licensed acupuncturist for anesthesia, ~~or~~ pain relief, or therapeutic treatment Physical therapy Occupational therapy Speech therapy Chiropractic services Cardiovascular, metabolic and pulmonary conditioning when we approve a supporting letter of medical necessity from your doctor.	PPO: 10% of the Plan allowance and any difference between the $2,000 per person , per year maximum Plan payment and the billed amount Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the $2,000 per person , per year maximum Plan payment and the billed amount	PPO: 10% of the Plan allowance and any difference between the $2,000 per person , per year maximum Plan payment and the billed amount Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the $2,000 per person , per year maximum Plan payment and the billed amount
Not covered: • *Long-term rehabilitative therapy, except speech therapy* • *Exercise programs* • *Maintenance cardiac rehabilitation*	*All charges*	*All charges*
Educational classes and programs		
Coverage is limited to: • Smoking Cessation – Up to $100 for one smoking cessation program per person per lifetime, including all related expenses such as prescription drugs. Note – Smoking cessation drugs and medications, including nicotine patches are not available under any other Plan provisions.	PPO: Same as non-PPO Non-PPO: Any difference between the $100 per person per lifetime Plan allowance and the billed amount	PPO: Same as non-PPO Non-PPO: Any difference between the $100 per person per lifetime Plan allowance and the billed amount
• Diabetes self-management.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount

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

IMPORTANT

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 (PPO) or $500 (non-PPO) per person ($500 PPO or $1000 non-PPO per family) under Standard Option and $200 (PPO) or $400 (non-PPO) per person ($400 PPO or $800 non-PPO per family) under the 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.
- The non-PPO benefits are the standard 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 surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)

IMPORTANT

Benefit Description	You pay After the calendar year deductible…	
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**You pay - Standard Option**	**You pay - High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • 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	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount. (No deductible)

Surgical procedures - Continued on next page

Surgical procedures – *continued*	**You pay - Standard Option**	**You pay - High Option**
• Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization, and Norplant (a surgically implanted contraceptive). • Treatment of burns	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
• Assistant surgeons – We cover up to 20% of the Plan allowance for the primary surgical charge	PPO: Nothing Non-PPO: Any difference between our allowance and the billed amount.	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (No deductible)
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, the plan allowance for all procedures after the primary procedure is half of the allowance the procedure would have if it were a primary procedure. Note: Multiple or bilateral surgical procedures performed through the same incision 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.	PPO: 10% of the Plan allowance for the primary procedure and any difference between our 50% allowance and the billed amount for subsequent procedures. Non-PPO: 30% of the Plan allowance for the primary procedure and any difference between our 50% allowance and the billed amount for subsequent procedures	PPO: 10% of the Plan allowance for the primary procedure and any difference between our 50% allowance and the billed amount for subsequent procedures (No deductible) Non-PPO: 20% of allowance for the primary procedure and any difference between our 50% allowance and the billed amount for subsequent procedures (No deductible)
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty* • *All procedures associated with treatment of temporomandibular disorders* • *Assistant surgery services provided by a non-physician provider such as a Physician Assistant (P.A.), Certified Registered Nurse First Assistant (C.R.N.F.A.) and a Certified Surgical Technologist (C.S.T.)*	*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 produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; 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; – breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage) Note: We pay for internal breast prostheses as hospital benefits when the hospital is billing for the prostheses. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Reconstructive surgery – Continued on next page

Reconstructive surgery – con*tinued*	**You pay - Standard Option**	**You pay - High Option**
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury or for the correction of congenital anomalies* • *Injections of silicone, collagens and similar substances* • *Surgeries related to sex transformation or sexual dysfunction or sexual inadequacy*	*All charges*	*All charges*
Oral and maxillofacial surgery		
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 stones from salivary ducts • Excision of tori, leukoplakia or malignancies • Excision of cysts and incision of abscesses not involving the teeth • Other surgical procedures that do not involve the teeth or their supporting structures • Removal of impacted teeth Note: When multiple or bilateral oral maxillofacial surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays the same benefits as indicated under Multiple surgical procedures for the above listed procedures. Note: Removal of impacted teeth are not considered multiple procedures.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth (other than impacted teeth) or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone – See dental benefits)*	*All charges*	*All charges*

Organ/tissue transplants	You pay - Standard Option	You pay - High Option
Limited to: • Cornea • Heart • Heart/lung • Kidney • Pancreas • Liver • 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. • Bone marrow transplants and stem cell support as follows: Allogeneic bone marrow for acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkins lymphoma, advanced neuroblastoma (children over age one), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, thalassemia major, and Wiskott-Aldrich syndrome. Autologous bone marrow transplants (autologous stem cell and peripheral stem support) for the following conditions: acute lymphocytic or nonlymphocytic leukemia; advanced Hodgkins lymphoma and advanced non-Hodgkins lymphoma; advanced neuroblastoma; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; breast cancer, multiple myeloma; and epithelial ovarian cancer. Limited Benefits – Benefits apply only if we cover the recipient and are limited to $100,000 per transplant. We must approve all related expenses prior to the surgery, including charges for procurement of cadaver organs. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	A portion of the Plan allowance for covered services and any amount over our $100,000 maximum per transplant. See sections 5(a), 5(b) and 5(c) for the portion you pay. See National Transplant Program on next page	A portion of the Plan allowance for covered services and any amount over our $100,000 maximum per transplant. See sections 5(a), 5(b) and 5(c) for the portion you pay See National Transplant Program on next page

Organ/tissue transplants – Continued on next page

Organ/tissue transplants – *continued*	**You pay - Standard Option**	**You pay - High Option**
National Transplant Program- Limited to the following preformed at the MAYO Clinic: • Bone marrow • Heart • Kidney/pancreas • Liver • Heart/lung • Single lung • Double lung Note: The MAYO Clinic does not perform intestine transplants. Note: Benefits include transportation and lodging provided by MAYO Clinic. Call us at 800/544-7111 for more details.	Nothing	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Services or supplies for or related to organ/tissue transplants for any diagnosis not specifically listed as covered including chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow or stem cell transplants, drugs or medications administered to stimulate or mobilize stem cells for transplant, and all other services or supplies which are not medically necessary or appropriate but for the non-covered procedure.* • *Allogeneic and autologus bone marrow and stem cell transplants for solid tumors except as noted above.* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*	*All charges*

Anesthesia	You pay - Standard Option	You pay - High Option
Professional services provided in – • Hospital (inpatient)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.	PPO: 10% of Plan allowance (No deductible) Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount. (No deductible)
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan 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 allowance (No deductible) Non-PPO: 20% of the Plan allowance and any difference between our allowance and billed amount. (No deductible) 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

IMPORTANT

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 5(c) the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". The calendar year deductible is: $250 (PPO) or $500 (non-PPO) per person or $500 (PPO) or $1000 (non-PPO) per family under Standard Option and $200 (PPO) or $400 (non-PPO) per person or $400 (PPO) or $800 (non-PPO) per family under the High Option.
- The non-PPO benefits are the standard 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).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay	
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; • 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. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area. Note: When the non-PPO hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	PPO: 10% of the Plan allowance Non-PPO: $250 per admission copayment and 30% of the Plan's covered charges and any difference between our covered charges and the billed amount. Note: If you use a PPO provider and a PPO facility, we may still pay non-PPO benefits if you receive treatment from a radiologist, pathologist, or anesthesiologist that is not a PPO provider. Note: If you are hospitalized at the MAYO Clinic for an accepted covered transplant or an accepted complex surgery, you pay nothing.	PPO: 10% of the Plan allowance Non-PPO: $150 per admission copayment and 25% of the Plan's covered charges and any difference between our covered charges and the billed amount. Note: If you use a PPO provider and a PPO facility, we may still pay non-PPO benefits if you receive treatment from a radiologist, pathologist, or anesthesiologist that is not a PPO provider. Note: If you are hospitalized at the MAYO Clinic for an accepted covered transplant or an accepted complex surgery, you pay nothing.

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 • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics • Take home items (including prescription drugs) Note: Medical supplies, appliances, medical equipment, and covered items billed by a hospital for use at home are covered under section 5(a) • Prosthetic devices such as artificial joints and pacemakers.	PPO: 10% of the Plan allowance Non-PPO: $250 per admission copayment and 30% of the Plan's covered charges and any difference between our covered charges and the billed amount Note: If you are hospitalized at the MAYO Clinic for a covered transplant or an accepted complex surgery, you pay nothing..	PPO: 10% of the Plan allowance Non-PPO: $150 per admission copayment and 25% of the Plan's covered charges and any difference between our covered charges and the billed amount. Note: If you are hospitalized at the MAYO Clinic for a covered transplant or an accepted complex surgery, you pay nothing.
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board at the level they would have been covered if provided in an alternative setting* • *Custodial care; see definition.* • *Non-covered facilities, such as nursing homes, extended care facilities (except when Medicare A is primary) and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Surcharges made by hospitals*	*All charges.*	*All charges.*

Outpatient hospital or ambulatory surgical center	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 oxygen • Anesthetics • Prosthetic devices such as artificial joints and pacemakers NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We cover dental procedures under the dental benefit. See section 5(h).	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Extended care benefits/Skilled nursing care facility benefits		
No benefit unless covered under Medicare Part A. Once Medicare has made their primary payment, we provide secondary benefits for the appropriate Medicare Part A deductible and coinsurance in full.	PPO: Nothing Non-PPO: Nothing	PPO: Nothing Non-PPO: Nothing
Not covered: • *Custodial care* • *Services and supplies for which Medicare Part A did not provide benefits*	*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 doctor. The hospice team may also include social workers, clergymen/counselors, volunteers, clinical psychologists, physical and occupational therapists. The hospice care program must begin after a person's primary doctor certifies terminal illness and life expectancy of six months or less. Hospice care must be: • Ordered by the supervising doctor, • Charged by the hospice care program, and • Provided within six months from the date the person entered (or re-entered after a period of remission) a hospice care program. Note: If you are in remission and discharged from a hospice care program, a readmission within three months of a prior discharge is considered as part of the same period of care. A new period begins three months after a prior discharge with maximum benefits available.	PPO: Same as non-PPO Non-PPO: Any difference between the Plan allowance and the billed amount Note: The Plan allowance is: • $150 per day up to $3,000 per period of inpatient care • 100% of covered charges up to $2,000 per period of outpatient care.	PPO: Same as non-PPO Non-PPO: Any difference between the Plan allowance and the billed amount Note: The Plan allowance is: • $150 per day up to $3,000 per period of inpatient care • 100% of covered charges up to $2,000 per period of outpatient care.
Bereavement benefit: Family bereavement counseling and supportive services if the covered family members receive the services from a hospice care program within three months following the death of a covered family member who received hospice care benefits under the Plan.	PPO: Same as non-PPO Non-PPO: Any difference between the $200 Plan allowance and the billed amount	PPO: Same as non-PPO Non-PPO: Any difference between the $200 Plan allowance and the billed amount
Not covered: Independent nursing, homemaker	*All charges.*	*All charges.*

Ambulance	You pay - Standard Option	You pay - High Option
• Local professional ambulance service when medically appropriate	PPO: Same as non-PPO Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: Same as non-PPO Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible is: $250 (PPO) or $500 (non-PPO) per person ($500 PPO or $1000 non-PPO per family) under Standard Option and $200 (PPO) or $400 (non-PPO) per person ($400 PPO or $800 non-PPO per family) under the 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.
- The non-PPO benefits are the standard 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, Y*our 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.

IMPORTANT

What is accidental injury/medical emergency?

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

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as bruised ribs, animal bites, and poisonings.

Benefit Description	You pay After the calendar year deductible…	
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury	**You pay - Standard Option**	**You pay - High Option**
If you receive care for your accidental injury within 72 hours, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services Note: We pay Hospital benefits if you are admitted.	PPO: Nothing (No deductible) Non-PPO: The difference between the Plan allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: The difference between the Plan allowance and the billed amount (No deductible)

Accidental injury -- Continued on next page

Accidental injury - *continued*	**You pay - Standard Option**	**You pay - High Option**
If you receive care for your accidental injury after 72 hours, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services Note: We pay Hospital benefits if you are admitted. See Section 5(c) for other hospital benefits and Section 5(b) for surgical benefits.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan allowance Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount
Medical emergency		
Outpatient medical or surgical services and supplies provided in a hospital emergency room.	PPO: 10% of the Plan allowance and a $50 copayment per access to care (No deductible) Non-PPO: 30% of the Plan allowance and a $50 copayment per access to care and any difference between the sum of our allowance plus the copayment and the billed amount (No deductible)	PPO: 10% of the Plan allowance and a $50 copayment per access to care (No deductible) Non-PPO: 20% of the Plan allowance and a $50 copayment per access to care and any difference between the sum of our allowance plus the copayment and the billed amount (No deductible)
Ambulance		
Professional ambulance service provided for accidental injury is covered under the accidental injury benefit. When a patient is provided ambulance service to an outpatient hospital emergency room for a medical emergency (non-accidental), we will cover as indicated in this section. Note: We cover air ambulance only when it is medically necessary and the physician provides a letter of medical necessity. Note: See 5(c) for non-emergency service.	PPO: Same as non-PPO Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)	PPO: Same as non-PPO Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

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

IMPORTANT

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 for other illnesses and conditions.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The mental health and substance abuse calendar year deductible or, for facility care, the inpatient deductible apply to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE IN-NETWORK SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are shown below, then Out-of-Network benefits begin on page 48.

IMPORTANT

Benefit Description	You pay After the mental health and substance abuse calendar year deductible
NOTE: The mental health and substance abuse calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
In-Network benefits	
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: 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. To request approval, advise your provider to fax a written treatment plan to the attention of: PBP Mental Health Coordinator at 703-836-8937.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management is paid as medical. See Section 5 (a) Note: Prescription drugs are paid under the Prescription drug benefit. See Section 5 (f)	10% of our allowance , after a mental condition/substance abuse calendar year deductible of $250 under Standard Option or $200 under High Option.

In-Network benefits -- Continued on next page.

In-Network benefits – *continued*	**You pay**
• Diagnostic tests – psychiatric • Diagnostic tests – medical are paid as medical. See Section 5(a)	10% of our allowance, after a mental condition/substance abuse calendar year deductible of $250 under Standard Option or $200 under High Option.
• Inpatient services provided by a hospital or other facility • Inpatient services in approved alternative care settings	10% of the Plan allowance.
• Outpatient services provided by a hospital or other facility • Outpatient services in approved alternative care settings	10% of the Plan allowance, after a mental condition/substance abuse calendar year deductible of $250 under Standard Option or $200 under High Option
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization

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

Advise your provider to fax a written treatment plan, for review and approval, to the attention: PBP Mental Health Coordinator at 703-836-8937, to initiate consideration of your case. To identify network providers, call 1-866-218-8317. We will not provide enhanced benefits for care received prior to our approval of a treatment plan.

Out-of-pocket limit

For those services with coinsurance, we pay **100%** of the Plan allowance for the remainder of the calendar year after out-of-pocket expenses for the mental health and substance abuse coinsurance for that calendar year exceed $3,500 per person per year or $4,000 per family under **Standard Option** and $3,000 per person per year or $3,500 per family under **High Option.**

Out-of-Network benefits	You pay
For mental conditions, we cover inpatient doctor visits provided during a covered admission.	A $300 annual deductible and 50% of the Standard Option Plan allowance or a $275 annual deductible and 20% of the High Option Plan allowance, and any difference between our allowance and the billed charges.
For mental conditions, we cover inpatient room and board and other hospital charges for up to 100 days per covered person each calendar year. Note: For individual cases, we may agree to cover hospital day treatment (partial hospitalization) the same as inpatient care. We consider two admissions separated by less than 30 days to be one admission.	A $500 per admission copayment, 40% of the Standard Option Plan allowance or 30% of the High Option Plan allowance, and any difference between our allowance and the billed charges.
For mental conditions, we allow up to $100 per visit for 25 outpatient visits per person per year. Note: Visits used to meet the deductible amount are not counted as part of the 25 visits.	A $300 annual deductible and 50% of the Standard Option Plan allowance or a $275 annual deductible and 50% of the High Option Plan allowance and any difference between our allowance and the billed charges
For substance abuse, we cover hospital inpatient care and services, outpatient services and supplies, and rehabilitation. This benefit is limited to a maximum.	A $500 annual deductible, 30% of the Plan allowance, and charges in excess of our allowance and the $3,500 per person per year maximum benefit.
Not covered: • *Treatment related to marital discord* • *Personal comfort items such as telephone and television, guest meals and beds, barber and beauty services* • *Custodial care (see page72)* • *Treatment for learning disabilities* • *Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staffs*	*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 should be reported immediately, but no more than 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 5(e), Mental health and substance abuse benefits provides the full information about the catastrophic protection for these benefits.*
- *Section 7, Filing a claim for covered services for information about submitting out-of-network claims.*

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The annual drug deductible is $100 per person for network retail pharmacies or $150 per person for non-network retail pharmacies for both Standard Option and High Option. The annual drug deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the annual drug deductible does not 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.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician or a licensed dentist must write the prescription**.**
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy or our mail order program for maintenance medication. To locate a network pharmacy in your area call NPA/BeneCard at 1-800-467-2006 or visit our website at http://www.postmasters.org/pbp.asp
- **We use a formulary.** The formulary identifies preferred name brand drugs. Our formulary applies to drugs received from a network retail pharmacy or our mail order program. Your copayment is less for drugs listed on our formulary than for those drugs not listed.

  We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-467-2006
- **These are the dispensing limitations.** We will cover up to a 30-day supply of covered drugs or supplies from network retail pharmacies or from non-network retail pharmacies. Call NPA/Benecard at 1-800-467-2006 or visit our website at http://www.postmasters.org/pbp.asp to locate a network retail pharmacy in your area. If you file a prescription at a non-network retail pharmacy, our benefit is based on the cost of the drug at a network retail pharmacy. Network pharmacies will not dispense a refill until enough time has passed for the prior prescription to be mostly used. You must present your prescription drug identification card when using a network retail pharmacy to receive network benefits. If you fail to present the card for any reason, non-network benefits will apply.

  You may purchase up to a 90-day supply of maintenance drugs through the Mail Order Drug Program. The Mail Order Drug Program will not dispense drugs that require constant refrigeration, are too heavy to mail, or that must be administered in a clinical setting.

  When a doctor prescribes different doses of the same medication on the same prescription, we consider each dose a new prescription, therefore a copayment would be required.

- The Mail Order Drug Program will dispense a generic equivalent drug if it is available, unless your doctor specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your doctor has not specified Dispense as Written for the name brand drug, you have to pay the difference in the cost between the name brand drug and the generic.

- **Why use generic drugs?** Generic drugs are the therapeutic equivalent of more expensive brand name drugs. Generic drugs are less expensive than the brand name drugs they replace. You may reduce your out-of-pocket costs by choosing to use generic drugs.

When you file a claim There is no claim to file when a network retail pharmacy or the mail order program fills prescriptions. We will send you information on the mail order drug program and how to file a claim for non-network retail pharmacies. You must complete the initial mail order form, enclose your prescription and copayment, and mail your order. Allow two weeks for delivery.

Benefit Description	You Pay After the annual drug deductible…	
NOTE: The annual drug deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Covered medications and supplies	**You pay - Standard Option**	**You pay - High Option**
Each new enrollee will receive a description of our prescription drug program, a prescription drug identification card, a mail order form/patient profile and a preaddressed reply envelope. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices	Network Retail: The greater of 20% or $15 generic, $30 formulary brand name, or $40 non-formulary brand name Network Retail Medicare: The greater of 20% or $15 generic, $30 formulary brand name, or $40 non-formulary brand name Non-Network Retail: 30% of the Plan allowance for a network pharmacy and any difference between our allowance and the billed amount. Non-Network Retail Medicare: 30% of the Plan allowance for a network pharmacy and any difference between our allowance and the billed amount.	Network Retail: The greater of 20% or $10 generic, $25 formulary brand name, or $40 non-formulary brand name Network Retail Medicare: The greater of 20% or $10 generic, $25 formulary brand name, or $40 non-formulary brand name Non-Network Retail: 20% of the Plan allowance for a network pharmacy and any difference between our allowance and the billed amount. Non-Network Retail Medicare: 20% of the Plan allowance for a network pharmacy and any difference between our allowance and the billed amount.

Covered medications and supplies – Continued on next page

Covered medications and supplies – *continued*	**You pay - Standard Option**	**You pay - High Option**
Each new enrollee will receive a description of our prescription drug program, a prescription drug identification card, a mail order form/patient profile and a preaddressed reply envelope. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not covered. • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices	Network Mail Order: $15 generic, $30 formulary brand name, or the greater of 20% or $40 non-formulary brand name (No deductible) Network Mail Order Medicare: $7 generic, $15 formulary brand name, or the greater of 20% or $25 non-formulary brand name. (No deductible) Note: If there is no generic equivalent available, you will still have to pay the brand name copayment.	Network Mail Order: $10 generic, $25 formulary brand name, or the greater of 20% or $40 non-formulary brand name (No deductible) Network Mail Order Medicare: $5 generic, $12 formulary brand name, or the greater of 20% or $25 non-formulary brand name (No deductible) Note: If there is no generic equivalent available, you will still have to pay the brand name copayment
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs to aid in smoking cessation other than those covered under the smoking cessation benefit.* • *Medical supplies such as dressings and antiseptics*	*All Charges*	*All Charges*

Section 5 (g). Special features

Special features	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
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-866-218-8317 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Complex surgery	The MAYO Clinic operates three facilities (Minnesota, Florida and Arizona) that specialize in providing efficient and economical complex surgical care such as hip/knee replacements, coronary bypass, heart valve replacement, or mastectomy. If the MAYO Clinic accepts your case, you pay nothing for the hospital and surgical care they render. Call us at 800/544-7111 for details about seeking care at the MAYO Clinic.
Centers of excellence for transplants	See National Transplant Program under Organ/Tissue transplant in Section 5(b). The MAYO Clinic operates three facilities (Minnesota, Florida and Arizona) that specialize in providing efficient and economical transplants for most organ transplants. If you receive a transplant, listed as covered under the Transplant Program, at the MAYO Clinic, you pay nothing for the hospital and surgical care they render. Call us at 800/544-7111 for details about seeking care at the MAYO Clinic.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to 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.
- There is a $30 per person annual dental deductible under High Option. There is no dental deductible under Standard Option.
- 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.
- Note: We cover hospitalization for dental procedures only when the patient has a non-dental physical impairment which makes hospitalization necessary to safeguard the patient's health.

IMPORTANT

Accidental injury benefit	You pay - Standard Option	You pay - High Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Note: Injury to the teeth from chewing or biting is not considered an accidental injury for purposes of this provision.	Any amount over the High Option Schedule of allowances.	Any amount over the High Option Schedule of allowances.

Dental benefits

We provide dental benefits for services listed in the following Schedule of dental allowances:

Under Standard Option, we cover charges up to the applicable allowance shown in the Schedule of dental allowances. There is no calendar year maximum.

Under High Option, after the $30 yearly dental deductible, we cover charges up to a percentage of the applicable allowance shown in the Schedule of dental allowances. This percentage depends upon the number of calendar years the member has been continuously enrolled under the High Option of this Plan, as follows: first calendar year, **50%** of scheduled allowance; second calendar year, **75%** of scheduled allowance, thereafter, **100%** of scheduled allowance.

Under High Option the maximum benefit payable for any calendar year is $800 per person, $2,000 per family. Only scheduled allowances shown in the Schedule of dental allowances may be applied toward the dental deductible or the maximum payable.

The following Schedule of dental allowances, is a complete list of covered dental services available.

Note: We pay actual charges up to the scheduled allowances.

Dental benefits	We pay (scheduled allowance)		You pay
Service	**Standard Option**	**High Option**	
Basic services			
Diagnostic			
Periodic oral evaluation (routine exams limited to two per year)	$6.50	$6.50	* All charges in excess of the scheduled amounts listed to the left
Limited oral evaluation – problem focused	$6.50	$6.50	*
Comprehensive oral evaluation	$9.00	$9.00	*
Detailed and extensive oral evaluation-problem focused, by report	N/A	$11.00	*
Intraoral, complete series including bite wings (limited to one every three years)	$15.00	$23.00	*
Intraoral periapical first film	$1.00	$3.50	*
Intraoral, periapical each additional film	$1.00	$1.00	*
Intraoral, occlusal film	$7.50	$7.50	*
Extraoral, first film	N/A	$7.00	*
Extraoral, each additional film	N/A	$7.00	*
Bitewing, single film	$3.00	$3.50	*
Bitewings, two films	$4.00	$6.50	*
Bitewings, four films (bitewings limited to two series per year)	$6.50	$9.50	*
Panoramic film (considered a complete series)	$15.00	$19.00	*
Pulp vitality	N/A	$7.00	*
Diagnostic casts	N/A	$15.50	*
Preventive			*
Prophylaxis, adult (age 14 or over) (prophylaxes or cleanings are limited to two per year)	$10.50	$14.50	*
Prophylaxis, child (under age 14) (prophylaxes or cleanings are limited to two per year)	$10.50	$10.50	*
Topical application of fluoride, including prophylaxis	$16.00	$17.00	*
Topical application of fluoride, prophylaxis not included (application of fluoride, limited to one per year and to children under age 14)	$5.50	$6.50	*
Space maintainer, fixed, unilateral	N/A	$77.50	*
Space maintainer, fixed, bilateral	N/A	$77.50	*
Space maintainer, removable, unilateral	N/A	$113.50	*
Space maintainer, removable, bilateral	N/A	$113.50	*
Recementation of space maintainer (space maintainer are passive appliance, schedule limit includes all adjustments)	N/A	$10.00	*

Restorative Note: Multiple restorations on one surface will be considered as a single restoration.	**Standard Option**	**High Option**	**You pay**
Amalgam, one surface, primary	$11.50	$13.50	*
Amalgam, two surfaces, primary	$16.50	$19.50	*
Amalgam, three surfaces, primary	$22.00	$25.00	*
Amalgam, one surface, permanent	$11.50	$14.50	*
Amalgam, two surfaces, permanent	$18.00	$22.00	*
Amalgam, three surfaces, permanent	$22.00	$29.50	*
Silicate cement	$16.50	$18.00	*
Resin, one surface	$11.50	$17.00	*
Resin, two surfaces	$18.00	$24.00	*
Resin, three surfaces	$22.00	$29.50	*
Pin retention, per tooth in addition to restoration	N/A	$10.50	*
Endodontics			
Pulp cap, direct	N/A	$9.50	*
Pulp cap, indirect	N/A	$9.50	*
Therapeutic pulpotomy	N/A	$17.50	*
Root canal, one	N/A	$108.00	*
Root canal, two	N/A	$131.00	*
Root canal, three or more	N/A	$178.50	*
Apexification/recalcification-initial visit	N/A	$7.00	*
Apicoectomy/periradicular surgery-anterior	N/A	$113.00	*
Periodontics			
Gingivectomy or gingivosplasty, per quadrant	N/A	$86.00	*
Gingivectomy or gingivosplasty, per tooth	N/A	$22.00	*
Gingival curettage, surgical, per quadrant, by report	N/A	$12.00	*
Gingival flap procedure including root planning, per quadrant	N/A	$33.50	*
Clinical crown lengthening-hard tissue	N/A	$90.00	*
Osseous surgery (including flap entry and closure) per quadrant	N/A	$194.00	*
Bone replacement graft-first site in quadrant	N/A	$84.00	*
Free soft tissue procedure (including donor site surgery)	N/A	$142.00	*
Provisional splinting, intracoronal	N/A	$33.50	*
Provisional splinting, extracoronal	N/A	$35.50	*
Periodontal scaling and root planing, per quadrant	N/A	$15.00	*
Periondontal maintenance procedure (following active therapy)	N/A	$19.50	*
Prosthodontics (removable) repairs			
Repair broken complete denture base	N/A	$26.00	*
Replace missing or broken teeth, complete denture (each tooth)	N/A	$5.00	*
Repair resin denture base	N/A	$25.00	*
Repair cast framework	N/A	$34.00	*
Repair or replace broken clasp	N/A	$20.00	*

Prosthodontics (removable) – Continued on next page

Prosthodontics (removable) repairs -c*ontinued*	**Standard Option**	**High Option**	**You Pay**
Replace broken teeth, per tooth	N/A	$5.00	*
Add tooth to existing partial denture	N/A	$11.00	*
Add clasp to existing partial denture	N/A	$24.00	*
Oral surgery (includes local anesthesia and routine postoperative care)			
Extraction, single teeth	$12.50	$17.00	*
Extraction, each additional tooth	$7.50	$14.50	*
Root removal, exposed roots	N/A	$18.00	*
Surgical removal of erupted tooth requiring elevation of mucoperiostael flap and removal of bone and/or section of tooth	$19.00	$24.00	*
Surgical removal of residual tooth roots (cutting procedure	N/A	$28.50	*
Surgical exposure of impacted or unerupted tooth to aid eruption	N/A	$46.50	*
Alveoloplasty in conjunction with extractions per quadrant	N/A	$30.50	*
Alveoloplasty not in conjunction with extractions per quadrant	N/A	$49.50	*
Removal of odontogenic cyst or tumor, lesion diameter up 1.25 cm	N/A	$42.00	*
Removal of odontogenic cyst or tumor, lesion diameter over 1.25 cm	N/A	$94.50	*
Incision and drainage of abscess, intraoral soft tissue	N/A	$24.50	*
Incision and drainage of abscess, extraoral soft tissue	N/A	$24.50	*
Excision of hyperplastic tissue, per arch	N/A	$67.00	*
Excision of pericoronal gingiva	N/A	$28.50	*
Adjunctive general services			
General anesthesia	N/A	$45.00	*
Analgesia	N/A	$9.00	*
Intravenous sedation	N/A	$43.00	*
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	N/A	$18.00	*
Office visit for observation (during regularly scheduled hours)	N/A	$6.50	*
Office visit, after regularly scheduled hours	N/A	$8.00	*
Occlusion analysis, mounted case	N/A	$17.50	*
Occlusal adjustment, limited	N/A	$25.00	*
Occlusal adjustment, complete	N/A	$110.00	*
Major services			
Restorative			
Gold foil, one surface	N/A	$24.50	*
Gold foil, two surfaces	N/A	$53.50	*
Gold foil, three surfaces	N/A	$74.50	*

Restorative – Continued on next page

Restorative – *continued*	**Standard Option**	**High Option**	**You Pay**
Inlay, metallic, one surface	N/A	$40.00	*
Inlay, metallic, two surfaces	N/A	$92.50	*
Inlay, metallic, three or more surfaces	N/A	$117.50	*
Inlay, porcelain/ceramic, one surface	N/A	$24.50	*
Inlay, porcelain/ceramic, two surfaces	N/A	$45.00	*
Inlay, porcelain/ceramic, three or more surfaces	N/A	$69.00	*
Crown, resin (laboratory)	N/A	$73.50	*
Crown, resin with high noble metal	N/A	$198.50	*
Crown, resin with predominantly base metal	N/A	$167.00	*
Crown, resin with noble metal	N/A	$182.50	*
Crown, porcelain/ceramic substrate	N/A	$184.00	*
Crown, porcelain fused to high noble metal	N/A	$215.50	*
Crown, porcelain fused to predominantly base metal	N/A	$184.00	*
Crown, porcelain fused to noble metal	N/A	$199.50	*
Crown, full cast high noble metal	N/A	$203.50	*
Crown, full cast predominantly base metal	N/A	$172.00	*
Crown, full cast noble metal	N/A	$188.00	*
Crown, ¾ cast metallic	N/A	$198.50	*
Recement inlay	N/A	$11.50	*
Recement crown	N/A	$11.50	*
Prefabricated stainless steel crown primary or permanent tooth	N/A	$40.00	*
Prefabricated resin crown	N/A	$40.00	*
Sedative filling	N/A	$8.00	*
Core buildup including any pins	N/A	$2.00	*
Cast post and core in addition to crown	N/A	$56.50	*
Prefabricated post and core in addition to crown	N/A	$32.00	*
Temporary crown (fractured tooth)	N/A	$40.00	*
Prosthodontics (removable)			
Complete upper or lower denture	N/A	$242.50	*
Immediate upper or lower denture	N/A	$275.00	*
Maxillary partial denture-resin (including any conventional clasps, rest and teeth)	N/A	$237.50	*
Mandibular partial denture-resin base (including any conventional clasps, rest and teeth)	N/A	$237.50	*
Maxillary partial denture-cast metal framework with resindenture bases (including any conventional clasps and teeth)	N/A	$271.00	*
Mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	N/A	$271.00	*
Removable unilateral partial denture-one piece cast metal (including clasps and teeth)	N/A	$157.50	*

Prosthodontics (removable) – Continued on next page

Prosthodontics (removable) – *continued*	**Standard Option**	**High Option**	**You pay**
Adjust complete upper or lower denture	N/A	$17.00	*
Adjust partial upper or lower denture	N/A	$17.00	*
Rebase complete denture	N/A	$94.50	*
Rebase partial denture	N/A	$71.00	*
Reline complete denture (chairside)	N/A	$56.50	*
Reline partial denture (chairside)	N/A	$43.00	*
Reline complete denture (laboratory)	N/A	$76.00	*
Reline partial denture (laboratory	N/A	$65.00	*
Interim complete denture	N/A	$115.50	*
Interim partial denture	N/A	$65.00	*
Tissue conditioning per denture unit	N/A	$20.00	*
Overdenture, complete, by report	N/A	$350.00	*
Overdenture, partial, by report	N/A	$280.00	*
Precision attachment, by report	N/A	$98.00	*
Prosthodontics (fixed)			*
Pontic, cast high noble metal	N/A	$204.00	*
Pontic, cast predominantly base metal	N/A	$172.00	*
Pontic, cast noble metal	N/A	$188.00	*
Pontic, porcelain fused to high noble metal	N/A	$215.50	*
Pontic, porcelain fused to predominantly base metal	N/A	$184.00	*
Pontic, porcelain fused to noble metal	N/A	$199.50	*
Pontic, resin with high noble metal	N/A	$222.00	*
Pontic, resin with predominantly base metal	N/A	$175.00	*
Pontic, resin with noble metal	N/A	$197.00	*
Inlay, metallic two surfaces	N/A	$92.50	*
Inlay, metallic three or more surfaces	N/A	$117.50	*
Retainer-Cast metal for resin bonded fixed prosthetics	N/A	$34.00	*
Crown, resin with high noble metal	N/A	$215.50	*
Crown, resin with predominantly base metal	N/A	$184.00	*
Crown, resin with noble metal	N/A	$199.50	*
Crown, porcelain fused to high noble metal	N/A	$234.00	*
Crown, porcelain fused to predominantly to base metal	N/A	$185.00	*
Crown, porcelain fused to noble metal	N/A	$205.00	*
Crown, ¾ cast high noble metal	N/A	$198.50	*
Crown, full cast high noble metal	N/A	$209.00	*
Crown, full cast predominantly base metal	N/A	$187.00	*
Crown, full cast noble metal	N/A	$185.00	*
Recement fixed partial denture	N/A	$21.00	*
Stress breaker	N/A	$56.50	*
Precision attachment	N/A	$92.50	*
Cast post and core in addition to fixed partial denture retainer	N/A	$66.00	*

Prosthodontics (fixed) – Continued on next page

Prosthodontics (fixed) - *continued*	**Standard Option**	**High Option**	**You pay**
Cast post as part of fixed partial denture retainer	N/A	$51.00	*
Prefabricated post and core in addition to fixed partial denture retainer	N/A	$37.00	*
Not covered: • *Services and supplies furnished by other than a licensed dentist, except for a prophylaxis (cleaning) which may be performed by a licensed dental hygienist working under the supervision of a dentist or an accredited school of dentistry* • *Dental services and supplies for which other benefits are payable* • *Replacement of bridges, dentures or appliances within five years of coverage of previous placement by this Plan* • *Fluorides for home use* • *Dental implants* • *Any dental service or supply for cosmetic purposes* • *Training in preventive care, oral hygiene or dietary practices* • *Orthodontic treatment*	N/A	N/A	*All charges*

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.

Long term care (LTC)

What would happen to your finances today if you required immediate long-term nursing home care? You may need benefits beyond those available through your FEHB Program or through Medicare's "skilled" nursing home benefits. Long term care (LTC) coverage is the answer. The League has secured the services of Long Term Preferred Care, Inc., the nation's premier long term care expert, to help you determine your needs. To find out more, call their toll-free line **(800)-742-1110** or visit their web site at **www.ltpc.com. Be sure to tell them you are a LEAGUE member.**

Supplemental Dental

All members of the League may enroll in the League Dental Program. The League does not require enrollment in the FEHB Plan for enrollment in the League Dental Program. The League Dental Program provides up to $1,000 of benefits per year. With the League Dental Program, you do not have to change from your current dentist. This program pays benefits directly to you, or to your dentist. Members may enroll in one of the three levels of coverage: individual, self and spouse, or family. Enrollees pay premiums quarterly. Coverage becomes effective the first of the month following receipt of your completed application and quarterly premium. For more information about benefits, limitations and premiums, and to request an application, write to: League Insurance Services, 4800 Montgomery Lane, M25, Bethesda, MD 20814. To get information by telephone, call toll free 1-800-522-1857.

Guaranteed Issue Life Insurance

Guaranteed issue group term life insurance is available to all PBP Health Plan enrollees. Two major private insurance companies, **US Life** and **American General**, are offering ALL PBP Health Plan enrollees guaranteed issue extra life insurance.

No health questions. No medical exams. Extra benefits for accidental death. Personal premiums are based on your age. For example, $15,000 of life insurance PLUS $15,000 of accidental death coverage for just $7.50 biweekly. **For details, call US Life Customer Service at 1-800-346-7692.**

Eyewear program

Outlook Vision Services Program offers you and your entire family all the saving advantages available only to Outlook Vision Services members from over **6000 Professional Vision Care Providers** in all **50 States and Puerto Rico**. The network includes national and regional vision care centers such as JC Penney Optical, Montgomery Ward, Royal Optical, Sears, Pearl Vision, For Eyes Only, Sterling Optical, Eye Masters. It also includes independent optometrists and opticians.

Best of all, as a member, you can save up to **50%** off the retail price of prescription glasses and sunglasses, contact lenses, nonprescription sunglasses, and accessories. For more information, contact Outlook Vision Services at: **Guardian Eagle Corporation, P. O. Box 84415, Sioux Falls, SD 57118** or **1-800-342-7188**

Non-FEHBP Benefits are not part of the FEHB contract

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless 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;
- 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, drugs, or supplies related to sex transformations; or sexual dysfunction; or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Charges that would not be made if covered individual had no health insurance coverage;
- Services furnished without charge (except as described on page 71; services rendered while in active military service; or services required for an illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories or possessions or (2) during combat;
- Services furnished by immediate relatives or household members, such as a spouse, parent, child, brother, or sister, by blood, marriage or adoption;
- Services furnished or billed by noncovered facility, except that medically necessary prescription drugs are covered;
- Services not specifically listed as covered;
- Services provided in connection with a noncovered service;
- 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, copay or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges neither you nor we have a legal obligation to pay, such as excess charges for annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 16), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge see page 17), or State premium taxes however applied;
- Routine preventive care, immunizations and all related expenses except as provided on pages 21, 22 and 23;
- Treatment for weight control or reduction (except morbid obesity);
- Social, recreational and educational services or training not specifically listed as covered
- Therapy, other than speech therapy, for developmental delays, learning disabilities, stuttering, tongue thrusting or deviate swallowing;
- Treatment of temporomandibular joint disorder;
- Services rendered by Christian Scientist providers (including sanitariums);

- Services rendered by massage therapists, rolfers, myotherapists, and trager clinics;
- Services rendered by hypnotherapists, neuromuscular therapists and naturopaths;
- Hospital benefits for admissions required for surgical procedures excluded by us
- Interest, completion of claim forms, or similar administrative charges made by providers;
- Travel, transportation, convalescent care or rest cures; or
- Services and supplies for cosmetic purposes such as Rogaine or wigs.

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 800/544-7111, or at our website at www.postmasters.org/pbp.asp

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. For claims questions and assistance, call us at 800/544-7111

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. See *Section 5(f), Prescription drug benefits* for information about special claim filing instructions.

Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Provider tax identification number (needed for assigned claims and PPO providers);
- 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 should include nursing notes.
- Claims for rental or purchase of durable medical equipment in excess of $300; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.

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

- You must include an English translation and currency conversion to U.S. dollars with claims for overseas (foreign) services.

- For dental claims, complete the member's section of the claim form and give it to the dentist to complete the remainder.

Submit Medical Claims To:
PBP Health Benefit Plan
PO Box 1040
Columbia, MD 21044

Submit Dental Claims To:
Attn: PBP Dental Unit
Vista Plan Administrators, Inc.
2556 Arthur Kill Road
Staten Island, NY 10309

Submit Mental and Substance Abuse Claims To:
PBP Health Plan
PO Box 1040
Columbia, MD 21044

Submit non-network Pharmacy Claims To:
BeneCard
168 Franklin Corner Road
Building 2, Suite 201
Lawrenceville, NJ 08648

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.

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed claim form and the itemized bills to:

PBP Health Plan
1019 N. Royal Street
Alexandria, VA 22314-1596.

Send any written inquiries concerning the processing of overseas claims to this address.

When we need more information

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

Section 8. The disputed claims process

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

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;

(b) Send your request to us at: PBP Health Plan
1019 N. Royal Street
Alexandria, Virginia 22314-1596

(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 II, 1900 E Street, Washington, D.C. 20415-3620.

The disputed claims process *(continued)*

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.

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 800/544-7111 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 II 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 health care expenses without regard to fault. This is called "double coverage."

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age 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 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 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 Medicare+Choice plan that 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 the Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. This provision applies when Medicare benefits are exhausted.

Claims process when you have the Original Medicare Plan -- You may never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In some cases, your claims will be coordinated automatically and we will pay 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 800/544-7111 or visit our website at www.postmasters.org/pbp.asp.

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

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive the calendar year deductible and coinsurance.
- Surgical and anesthesia services provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we waive the calendar year deductible and the coinsurance.
- Services provided by a hospital or other facility, and ambulance services. If you are enrolled in Medicare Part A, we waive the per admission copayment and the coinsurance. If you are enrolled in Medicare Part B, we waive the calendar year deductible and the coinsurance for covered ambulance services.
- Emergency services/Accidents. If you are enrolled in Medicare Part B, we waive the coinsurance and copayment for covered emergency room charges. If you are enrolled in Medicare Part B, we waive the calendar year deductible and the coinsurance for covered ambulance services.
- Mental health and substance abuse. If you are enrolled in Medicare Part A, we waive the per admission copayment and the mental health and substance abuse coinsurance. If you are enrolled in Medicare Part B, we waive the mental health and substance abuse deductible and coinsurance.

In cases where we cover a service that is not covered by Medicare, we are the primary payer. In these cases, we do not waive any out-of-pocket costs.

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		]
c) Are a former spouse of an annuitant	]	
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 when your Medicare managed care plan is primary, even out of the managed care plan's 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 the Original Medicare Plan 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.

•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.

•If you do not enroll in Medicare Part A or Part B

If you do not have 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.

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

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Assignment

An authorization by you or your spouse for us to issue payment or benefits directly to the provider. We reserve 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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

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 13.

Covered services

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

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 we 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.

Cosmetic surgery

Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

(1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
(2) homemaking, such as preparing meals or special diets;
(3) moving the patient;
(4) acting as companion or sitter;
(5) supervising medication that can usually be self administered; or
(6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respiration, or administration and monitoring of feeding systems.

We determine which services are custodial care.

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 13.

Durable medical equipment

Equipment that:

(1) is prescribed by your attending doctor;
(2) is medically necessary;

(3) is primarily and customarily used only for a medical purpose;
(4) is generally useful only to a person with illness or injury;
(5) is designed for prolonged use; and
(6) serve a specific therapeutic purpose in treatment of an illness or injury.

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 means 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, 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, or medical treatment or procedure.

Note: We use a formal procedure to determine if a service is experimental or investigational. We review claims with no procedure codes or experimental procedure codes. Physicians and medical specialists review complex claims and recommend whether we should consider the procedure to be experimental or investigational. We make the final decision.

A service or supply may be experimental or investigational if a:
- Product is not FDA approved,
- Service or treatment is still in some stage of trials,
- Service or treatment is not normally used to treat your condition, or
- Provider requires that you sign a special release prior to receiving the care.

Enrollees who have a question about a specific service or supply may call us at 800/544-7111

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.

Home health care agency

An agency or organization that provides a program of home health care that meets all the following requirements: (1) it is certified by the patient's doctor as an appropriate provider of home health services; (2) it has a full-

time administrator; (3) it maintains written records of services provided to the patient; and (4) its staff includes at least one registered nurse(R.N.).

Incurred date

The date services and supplies are received. The applicable benefits are those in effect on this date. The incurred date for major dental care expenses that involve preparatory services is the date the inlay, crown, bridge or denture is seated, placed or installed in the patient's mouth.

Medical necessity

Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that we determine;

(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 or dentally necessary.

Mental conditions/substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by us or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

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:

We refer to national databases such as those provided by St Anthony Publishing to determine the prevailing health care charges in a given geographic area. We use the 70th percentile of those charges as the Plan allowance for a given covered service in a geographic area. In some cases such as Dental benefits, the Plan Allowance is printed in this brochure. Charges subject to the Plan Allowance include, but are not limited to, charges for all surgery, anesthesia, medical care and mental health care.

We also use special industry or federal guidelines or consult with medical specialists to establish an allowance based on unusual cases or complex care. When we negotiate a discounted fee on an individual claim, that fee is the Plan Allowance. The fees that are negotiated with network providers as part of their network contract are considered the Plan Allowances. If you use a network provider, your cost is limited to the cost sharing provisions listed in this brochure's benefit charts. If you use a non-network provider, you are also responsible for charges in excess of the Plan allowance.

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

Remission

A remission is the halt or actual reduction in the progression of illness resulting in discharge from a hospice care program with no further expenses incurred. A readmission within three months of a prior discharge is considered as part of the same period of care. A new period begins three months after a prior discharge with maximum benefits available.

Sound natural tooth

A natural tooth that is whole or properly restored, without impairing periodontal or other conditions and not in need of the treatment rendered or proposed for any reason other than accidental injury.

Surgery

A " surgical procedure" means cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, endoscopy or injecting sclerosing solution.

Us/We

Us and we refer to PBP Health Plan

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/insure. 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;
- 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.

•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/insure. It explains what you have to do to enroll.

•Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1966 (HIPPA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPPA" frequently asked questions. These highlight HIPPA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPPA, 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 an 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. It 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 them will. And it's not just the 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, or 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 planing.

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 easily 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 aide to help you get 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 ~~the~~ 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. {RV: 7-26}*

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.

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.

Index

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

Notes

Notes

Notes

Summary of benefits for the PBP Health Plan - Standard Option - 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 ($500 non-PPO) calendar year 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
Medical services provided by physicians:	PPO: 10%*	
• Diagnostic and treatment services provided in the office	Non-PPO: 30%*	19
Services provided by a hospital:		
• Inpatient	PPO: 10%, non-PPO: 30%	39
• Outpatient	PPO: 10%*, non-PPO: 30%*	41
Emergency benefits:		
• Accidental injury	PPO: $0, non-PPO: charges over our allowance	44
• Medical emergency	PPO: $50 then 10%, non-PPO: $50 then 30%	45
Mental health and substance abuse treatment	PPO: Same as medical Non-PPO: Reduced benefits	46
Prescription drugs		
• Network retail	20% of network allowance or $15 generic, $30 formulary, or $40 brand name	50
• Non-network retail	30% of network allowance and amounts over our allowance	50
• Mail order	$15 generic, $30 formulary, or 20% of the network allowance or $40 for non-formulary.	51
• Mail order with Medicare	$7 generic, $15 formulary, or 20% of the network allowance or $25 for non-formulary.	51
Dental Care	Charges over our fee schedule	53
Special features: MAYO Clinic's center of excellence transplants, flexible benefits option, 24-hour nurse line		52
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $3,500 ($5,000 non-PPO) per person or $4,000 ($5,500 non-PPO) per family per year Some costs do not count toward this protection	15

Summary of benefits for the PBP Health Plan - High Option - 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 ($400 non-PPO) calendar year 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
Medical services provided by physicians:	PPO: 10%*	
• Diagnostic and treatment services provided in the office	Non-PPO: 20%*	20
Services provided by a hospital:		
• Inpatient	PPO: 10%, non-PPO 25%	39
• Outpatient	PPO: 10%*, non-PPO: 20%*	41
Emergency benefits:		
• Accidental injury	PPO: $0, PPO: charges over our allowance	44
• Medical emergency	PPO: $50 then 10%, non-PPO: $50 then 20%	45
Mental health and substance abuse treatment	PPO: Same as medical Non-PPO: Reduced benefits	46
Prescription drugs		
• Network retail	20% of network allowance or $10 generic, $25 formulary, or $40 brand name	50
	20% of network allowance and amounts over our allowance	50
• Non-network retail	20% of network allowance or $10 generic, $25 formulary, or $40 brand name	
• Mail order	$10 generic, $25 formulary, or 20% of the network allowance or $40 for non-formulary.	51
• Mail order with Medicare	$5 generic, $12 formulary, or 20% of the network allowance or $25 for non-formulary.	51
Dental Care	Charges over our fee schedule	53
Special features: MAYO Clinic's center of excellence transplants, flexible benefits option, and 24-hour nurse line		52
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $3,000 ($3,500 non-PPO) per person or $3,500 ($4,000 non-PPO) per family per year Some costs do not count toward this protection	15

2002 Rate Information for
PBP Health 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 U.S. 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	361	$ 97.86	$163.42	$ 212.03	$354.08	$115.52	$145.76
High Option Self and Family	362	$ 223.41	$ 340.32	$ 484.06	$ 737.36	$ 263.75	$ 299.98
Standard Option Self Only	364	$ 97.86	$ 50.95	$ 212.03	$ 110.39	$ 115.52	$ 33.29
Standard Option Self and Family	365	$ 223.41	$ 98.50	$ 484.06	$ 213.41	$263.75	$ 58.16