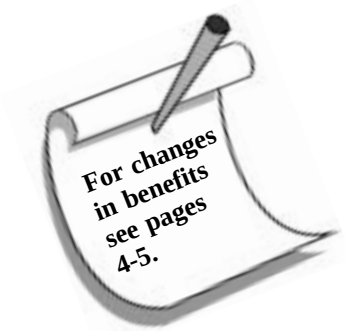
Postmasters Benefit Plan 2000

A Managed Fee-for-Service Plan
with a Preferred Provider Organization
Administered by the
National League of Postmasters



Sponsored by: the National League of Postmasters of the United States.

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the Federal Employees Health Benefits Program and who are, or become, members or 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.

Annuitants (retirees) may enroll in this Plan.

Membership dues: New League Benefit Members will be billed separately $35 for annual dues when the Plan receives notice of enrollment. Continuing members will be billed by the League for the annual membership dues.

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 code for this Plan:

HIGH OPTION
361 Self only
362 Self and family

STANDARD OPTION
364 Self only
365 Self and family

Visit the OPM website at http://www.opm.gov/insure
and
Our website at http://www.postmasters.org/pbp.asp

Authorized for distribution by the:

United States Office of Personnel Management

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Table of Contents

Introduction

Postmasters Benefit Plan, 1019 North Royal Street, Alexandria, Virginia 22314-1596

This brochure describes the benefits you can receive from the Postmasters Benefit Plan, sponsored by the National League of Postmasters under its contract CS 1071 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This Plan is underwritten by the National League of Postmasters with reinsurance from the Lexington Insurance Company.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. Nothing anyone says can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

Because OPM negotiates benefits and premiums annually they change each year. This brochure describes the only benefits available to you under this Plan in 2000. Benefit changes are effective January 1, 2000, and are shown on page 4. You do not have a right to benefits that were available before January 1, 2000, unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

Plain Language

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

We refer to the Postmasters Benefit Plan as "this Plan" throughout this brochure even though in other legal documents, you will see a Plan referred to as a carrier.

Sections one, two, four, and ten are now in plain language, as well as portions of sections three and eight. We will rewrite the remaining sections of this brochure, including the benefits section, for year 2001. Please note that the format and organization of this brochure have changed as well.

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

How to use this brochure

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

1. **Fee-for-Service Plan (FFS).** This Plan is a FFS Plan. Turn to this section for a brief description of Fee-for-Service Plans and how they work.
2. **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.
3. **How to get benefits.** Make sure you read this section; it tells you how to get benefits and how we operate.
4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim (or a portion of your claim).
5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. **How to file a claim.** Look here to find specific information on how to file claims with us.
7. **General exclusions – Things we don't cover.** Look here to see benefits that we will not provide.
8. **Limitations – Rules that affect your benefits.** This section describes limits that can affect your benefits.
9. **Fee-for-Service Facts.** This section contains information about precertification, protection against catastrophic expenses, and a definition section.
10. **FEHB facts.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Fee-for-Service Plans

Fee-for-service Plans reimburse you or your provider for covered services. They do not typically provide or arrange for health care. Fee-for-service Plans let you choose your own physicians, hospitals, and other health care providers.

The FFS Plan reimburses you for your health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by Plan. The type and extent of covered services varies by Plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

This FFS Plan offers a preferred provider organization (PPO) arrangement through a company called First Health Group Corp., which provides a PPO known as the First Health Medical Network. This arrangement with health care providers gives you enhanced benefit payments or limits your out-of-pocket expenses when you receive care from a PPO provider.

Section 2. How we change for 2000

Do not rely on this page. It is not an official statement of benefits.

Program-wide changes

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

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

If you have a chronic or disabling condition or are in the second or third trimester of pregnancy, and your specialist is leaving our PPO network at our request without cause, we will notify you. You may continue to receive our PPO level benefits for your specialist's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialist's services after the 90 day period expires.

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

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

Changes to this Plan

Both Options

- The catastrophic protection provision no longer applies to prescription drug coverage.
- Our PPO payment level for outpatient hospital services and professional services is reduced from 95% to 90%.

High Option

- The calendar year deductible for prescriptions filled at a participating pharmacy is reduced from $100 to $50 and the 20% paid by the patient is reduced to a $5 copayment for generic drugs and a $12 copayment for brand name drugs. We continue to pay the balance in full. The benefit for prescriptions filled at a non-participating pharmacy is not changed.
- Your share of the High Option PBP premium will increase by 5.5% for Self Only or 5.2% for Self and Family.
- For Postal Premium A employees, your share of the High Option PBP premium will increase by 4.9% for Self Only or 1.8% for Self and Family.
- For Postal Premium B employees, your share of the High Option PBP premium will increase by 4.7% for Self Only or 4.8% for Self and Family.

Section 2. How we change for 2000 *continued*

Standard Option

- The deductible for admission to a Non-PPO hospital is reduced from $600 to $250.
- The $350 deductible for admission to a PPO hospital is eliminated.
- The calendar year covered expenses, which the enrollee must pay out-of-pocket, before receiving Non-PPO benefits at the 100% level under the Catastrophic Protection provision, is reduced from $6,700 to $4,500.
- Our payment rate for covered hospital services rendered by a PPO hospital increases from 95% to 100%.
- The PPO office visit copayment is decreased from $20 to $10, and now includes x-rays, labs and surgeries rendered during the visit.
- The Point-of-Service (POS) program is eliminated. Non-PPO and PPO benefits remain.
- Your share of the Standard Option PBP premium will increase by 4.2% for Self Only or 3.4% for Self and Family.
- For Postal Premium A employees, your share of the Standard Option PBP premium will increase by 1.6% for Self Only or decrease -9.5% for Self and Family.
- For Postal Premium B employees, your share of the Standard Option PBP premium will increase by 0.9% for Self Only or increase 1.2% for Self and Family.

Section 3. How to get benefits

How do I keep my health care expenses down?

You can help

FEHB Plans are expected to manage their costs prudently. All FEHB Plans have cost containment measures in place. All fee-for-service Plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and the flexible benefits option. Some include managed care options, such as PPO's, to help contain cost.

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with First Health Group Corp., before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on page 38 of this brochure.

Flexible benefits option

Under the flexible benefits option, we have the authority to determine the most effective way to provide services. We may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. We may decide to resume regular contract benefits at our sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely ours and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

PPO

We offer most of our members the opportunity to reduce out-of-pocket expenses by choosing providers who participate in our preferred provider organization (PPO). Consider the PPO cost savings when you review Plan benefits and check with First Health Group Corp., to see whether PPO providers are available in your area.

Section 3. How to get benefits *continued*

How much do I pay for services?

You must share the cost of some services. These cost sharing measures include deductibles, coinsurance and copayments. These measures are described in more detail below.

- The copayments for Mail Order Prescription Drugs are waived under both options when Medicare Part B is the primary payer. (see page 24)
- The coinsurance may be waived when Medicare is primary. (see page 34)
- The coinsurance is not applied after the Catastrophic out-of-pocket expense limit is met. (see page 39)

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of expenses an individual must incur for covered services and supplies each calendar year before the Plan pays certain benefits. The deductible is $200 (PPO) or $275 (Non-PPO) for the **High Option** and $200 (PPO) or $350 (Non-PPO) for the **Standard Option**. Under High Option, only charges for services covered under Other Medical Benefits would apply to this deductible. Under Standard Option, only charges for services covered under Surgical Benefits, and Other Medical Benefits would apply to this deductible. Standard Option is subject to a separate deductible for mental condition inpatient hospital visits and outpatient care.

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

Drug

Under **High Option** there is a $100 calendar year drug deductible for non-participating pharmacies, a $50 calendar year drug deductible for participating pharmacies and no deductible for the Mail Order Drug program. Under **Standard Option**, there is a $100 calendar year drug deductible for non-participating pharmacies and a $50 calendar year drug deductible that applies to participating pharmacies and the Mail Order Drug Program. See pages 23-24 for waivers that apply to Medicare Part B enrollees.

Hospital

The per person admission deductible does not apply for admissions to PPO hospitals for either High Option or Standard Option. The per admission deductible for Inpatient Hospital Benefits, when using a non-PPO hospital, is $150 for the **High Option** and $250 for the **Standard Option** (see page 13). The **High Option** and **Standard Option** deductible for mental conditions is $500 per admission. The **High Option** and **Standard Option** deductible for substance abuse is $500 per person per year.

Dental

The **High Option** deductible for Basic and Major Dental Benefits is $30 per person per calendar year. There is no **Standard Option** deductible for Dental Benefits.

Carryover

If you changed to this Plan during open season from a Plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that Plan's deductible in the prior year will be covered by your old Plan if they are for care you received in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old Plan will reimburse these covered expenses. If you have not met it in full, your old Plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old Plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Family limit

There is a separate calendar year deductible of $200 (PPO) or $275 (Non-PPO) per person under the **High Option** and $200 (PPO) or $350 (Non-PPO) per person under the **Standard Option**. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the deductible for all family members reach $400 (PPO) or $550 (Non-PPO) under **High Option** and $400 (PPO) or $700 (Non-PPO) under **Standard Option** during a calendar year. If two or more persons under the same family enrollment are injured in the same accident, only one deductible need be satisfied that calendar year by those injured.

Section 3. How to get benefits *continued*

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The Plan will base this percentage on either the billed charge or the reasonable and customary charge, whichever is less. For instance, when a Plan pays 80% of reasonable and customary charges for a covered service, you are responsible for 20% of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges $100 for a service but the Plan's reasonable and customary allowance is $95, the Plan will pay 80% of the allowance ($76). You must pay the 20% coinsurance ($19), plus the difference between the actual charge and the reasonable and customary allowance ($5), for a total member responsibility of $24. Remember, if you use preferred providers, your share of covered charges (after meeting any deductible) is limited to the stated coinsurance amount.

When hospital charges are limited by law

When inpatient claims are paid according to a Diagnostic Related Group (DRG) limit (for instance, for admissions of certain retirees who do not have Medicare – see page 37), the Plan will consider 30% of the total covered amount as room and board charges and 70% as other charges and will apply your coinsurance accordingly.

Copayments

A copayment is the stated amount the Plan requires you to pay for a covered service, such as $10 per prescription by mail or $10 per office visit charge at a PPO provider.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges $100 for a service but routinely waives the 20% coinsurance, the actual charge is $80. The Plan will pay $64 (80% of the actual charge of $80).

Lifetime maximums

Both Options - The Plan will pay up to $100 for enrollment in one smoking cessation program per member per lifetime.

Do I have to submit claims?

You usually do not have to submit claims to us if you use preferred providers. If you file a claim, please send us all of the documents for your claim. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline, if you show that circumstances beyond your control prevented you from filing on time.

Please see section 6, How to file a claim, for specific information you need to know before you file a claim with us.

Who provides my health care?

In a fee-for-service Plan, you may choose any covered facility or provider.

Covered facilities

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 Organizations for treatment of substance abuse.

Hospice

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

Hospital

(l) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations, 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.

Section 3. How to get benefits *continued*

Rehabilitation Facility

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.

Covered providers

For purposes of this Plan, covered providers include:

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.) practicing within the scope of their license. 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. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 2000, the States designated as medically underserved are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, South Carolina, South Dakota, Utah, and Wyoming.

PPO arrangements

Benefits under this Plan are available from facilities, such as hospitals, and from providers, such as doctors and other health care personnel, who provide covered services. This Plan covers two types of facilities and providers: (1) those who participate in a preferred provider organization (PPO) and (2) those who do not. Who these health care providers are, and how benefits are paid for their services, are explained below. In general, it works like this.

PPO facilities and providers have agreed to provide most services to Plan members at a lower cost than you'd usually pay a non-PPO provider. Although PPO's are not available in all locations or for all services, when you use these providers you help contain health care costs and reduce what you pay out of pocket. The selection of PPO providers is solely the Carrier's responsibility; continued participation of any specific provider cannot be guaranteed. While PPO providers agree with the Carrier to provide covered services, final decisions about health care are the sole responsibility of the doctor and patient and are independent of the terms of the insurance contract.

PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. The availability of every specialty in all areas cannot be guaranteed. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

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

Non-PPO facilities and providers do not have special agreements with the Carrier. The Plan makes its regular payments toward their bills, and you're responsible for any balance.

Section 3. How to get benefits *continued*

This Plan's PPO

The Plan provides a national network of Preferred Provider Organizations (PPO) through a company called First Health Group Corp. This PPO network, First Health Medical Network, offers hospitals and doctors in numerous geographic areas; however, the number or type of providers may be insufficient in some geographic areas. Network providers have agreed to provide services to Plan enrollees and their dependents at negotiated rates. PPO benefits are available for inpatient and outpatient hospital services, inpatient and outpatient services of doctors, surgical procedures and anesthesia. The Carrier is solely responsible for the selection of PPO providers and any questions regarding PPO providers should be directed to the Plan. The continued participation of any specific PPO provider cannot be guaranteed. The patient can confirm the current sufficiency or limitation of the PPO network, in the area where they intend to receive care, by calling toll-free, the PPO InfoLine, or by visiting our website at www.postmasters.org/pbp.asp. The PPO InfoLine offers Plan members a toll-free number 1-800/654-6530, to obtain up-to-date information on the current status of providers within the Network. The PPO InfoLine operates 24 hours a day, 7 days a week. The Plan is not responsible for benefits in excess of the non-PPO level of benefits based on the patient not confirming the current sufficiency of PPO providers.

If you need hospital services, and a PPO hospital is available in your area, you may choose between a PPO provider and a non-PPO provider at the time of service. The rates that have been negotiated with the PPO Providers will result in savings to you through a higher level of benefit payment. When a **High Option** or **Standard Option** enrollee uses one of the PPO hospitals, there is no per admission room and board deductible. The Plan will also pay covered Other charges at **100%** under **High Option** and **Standard Option**.

In addition to savings on the PPO hospitals, the Plan offers a PPO Doctors Network. Participating providers will provide discounted charges. The Plan will pay **90%** of the discounted charges (after any deductibles).

The enrollees identification card will identify the patient as a participant of the First Health Group Corp., PPO network and will alert medical care providers that the enrollee participates in the Preferred Provider network (PPO). If an enrollee elects to use a non-PPO provider the Plan will provide its usual coverage as outlined in this brochure. Note: Some discounts can be obtained from network providers even though PPO benefits may not apply (see pages 18, 19, 20 and 21 for services not covered under PPO benefits). When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

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

First, call our customer service department at 703/683-5585. If you are new to the FEHB Program, we will reimburse your covered expenses. Expenses incurred prior to your effective date are not covered expenses. If you are currently in the FEHB Program and are switching to us, your former Plan will pay for the hospital stay until:

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

These provisions only apply to the person who is hospitalized.

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

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

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

If you continue seeing your specialist or OB/GYN under these conditions, your cost will be no more than you would normally pay for the services covered.

Section 3. How to get benefits *continued*

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

Claims with no procedure codes or experimental procedure codes are reviewed by PBP's Technical Advisory Dept., to determine whether the procedure is or is not experimental or investigational. Claims requiring a review by a physician or specialist are sent to First Health Group Corp., for review by appropriate physicians and specialists who recommend whether the services should or should not be considered experimental or investigational. PBP is responsible for the final decision. Enrollees who have a question about a specific service or supply may call us. Several things suggest that a service or supply may be experimental or investigational.

- If a product is not FDA approved, it may be experimental or investigational.
- If a service or treatment is still in some stage of trials, it is experimental or investigational.
- If a service or treatment is not normally used to treat your condition, it may be experimental or investigational.
- If a provider requires that you sign a special release prior to receiving the care, it may be experimental or investigational.

The determination of what is experimental or investigational changes over time. Services that were once experimental, such as a heart transplant, may not be experimental today**.** Services do not move from experimental to non-experimental overnight. They usually take time to be fully recognized as non-experimental.

Experimental or investigational defined

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 show 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.

Section 4. What to do if we deny your claim

What should I do before filing a disputed claim?

Before you ask us to reconsider your claim, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did they use the correct procedure code for the services performed (surgery, laboratory test, X-ray, office visit, etc.)? Have your provider indicate any complications of any surgical procedures performed. Your provider should also include copies of an operative or procedure report, or other documentation that supports your claim.

If we won't pay your claim (or a portion of your claim), you may ask us to reconsider our decision. Your request to us must:

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

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

1. Maintain our denial in writing;
2. Pay the claim; or
3. Ask for more information.

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

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal and we have maintained our denial in writing. OPM will determine if we correctly applied the terms of our contract when we denied your claim.

What if you have denied my claim and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your request, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division II at (202) 606-3818 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

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

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

What do I send to OPM?

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

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

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

Section 4. What to do if we deny your claim

Who can make the request?

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

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

What if OPM upholds the Plan's denial?

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

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

Where should I mail my disputed claim to OPM?

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

What laws apply if I file a lawsuit?

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

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above (as established at section 890.105, title 5, Code of Federal Regulations (CFR)). As required by 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal Court.

Your records and the Privacy Act

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

Section 5. Benefits

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See page 38 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. For information on when Medicare is primary, see page 34.

Room and board

The Plan pays the following for room and board (except for mental conditions or substance abuse treatment) for ward, semiprivate or intensive care. Special diets and general nursing care are included.

PPO benefit	**High Option** - Plan pays full charges (no deductible).	**Standard Option -** Plan pays full charges (no deductible).

See page 9 for information on PPO hospitals.

Non-PPO benefit	**High Option** - After a $150 per admission deductible, Plan pays full charges.	**Standard Option** - After a $250 per admission deductible, Plan pays **70%** of covered charges.

If a private room is used, both options will pay the average semiprivate rate charged by the hospital. If the hospital has private rooms only, the average semiprivate rate is determined on the basis of the semiprivate charge of the most comparable hospital in the area or the billed charge, whichever is less. If the patient's isolation is required to prevent contagion of others, the private room charge will be covered.

Other charges

Hospital services and supplies, including, but not limited to, use of operating, treatment and recovery rooms; Xrays and lab tests; chemotherapy; drugs and medicines for use in the hospital; and blood or blood plasma not donated or replaced.

PPO benefit	**High Option** - Plan pays **100%** of covered charges.	**Standard Option** - Plan pays **100%** of covered charges.
Non-PPO benefit	**High Option** - Plan pays **85%** for the first 30 days, then **100%** of covered charges.	**Standard Option** - Plan pays **70%** of covered charges.

Limited benefits

Hospitalization for dental work

The Plan pays Inpatient Hospital Benefits for covered room and board charges and covered hospital services and supplies in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient.

Weekend admissions

Benefits for hospital admissions on Friday or Saturday are limited to: (1) a medical emergency, (2) surgery performed within 24 hours of admission, or (3) a childbirth-related admission.

Related benefits

Preadmission testing

Preadmission testing is covered under Other Medical Benefits (page 19).

Professional charges

Charges for professional services of a doctor or any other practitioner covered by this Plan, even though billed by a hospital as part of hospital services, are covered only under Other Medical Benefits (page 19), except for inpatient pathology and radiology charges, which are payable as described above under Other charges.

Section 5. Benefits *continued*

Take-home items Drugs, medical supplies, appliances, medical equipment and any other covered items billed by a hospital to be used at home are covered only under Other Medical Benefits (pages 19-21).

What is not covered

- Personal comfort items such as telephone and television, guest meals and beds, barber and beauty services.
- Custodial care (see definition, page 40).
- Room and board when the medical services did not require the acute hospital inpatient setting, but could have been provided safely on an outpatient basis; or in facilities that are primarily (1) convalescent nursing homes, hotels or homes for the aged whose primary purpose is to furnish custodial care; (2) operated as schools; or (3) places for drug addicts or alcoholics, except as provided for Substance abuse rehabilitation on page 19.
- Private duty nursing care while confined in a hospital
- Surcharges made by hospitals

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.

Surgical Benefits

What is covered The Plan pays for the following services:

Hospital inpatient and outpatient For covered surgical procedures:

PPO benefit **Both Options** - The Plan pays **90%** of the surgeon's negotiated rate (after the $200 calendar year deductible has been met for **Standard Option**).

Non-PPO benefit

High Option - The Plan pays **85%** of the reasonable and customary allowance.

Standard Option - After the $350 calendar year deductible has been met, the Plan pays **70%** of the reasonable and customary allowance.

Multiple surgical procedures When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays as follows:

PPO benefit **Both Options** - The Plan pays **90%** of the surgeon's negotiated rate (after a $200 calendar year deductible has been met for **Standard Option**) for the major procedure and no more than **50%** of the surgeon's negotiated rate for all subsequent procedures.

Non-PPO benefit

High Option - The Plan pays **85%** of the reasonable and customary allowance for the first or major procedure and **50%** of the reasonable and customary allowance for the second or lesser procedure(s).

Standard Option - After the $350 calendar year deductible has been met, the Plan pays **70%** of the reasonable and customary allowance for the first or major procedure and **50%** of the reasonable and customary allowance for the second or lesser procedure(s).

Incidental procedures **Both Options** - When an incidental procedure (e.g., incidental appendectomy, lysis of adhesions, excision of scar) is performed through the same incision, the reasonable and customary allowance will be that of the major procedure only.

Assistant surgeon (inpatient/outpatient)

PPO benefit

High Option - The Plan pays **20%** of the negotiated rate.

Standard Option - After the $200 calendar year deductible has been met, the Plan pays assistant surgeons' fees up to **15%** of the negotiated rate.

Section 5. Benefits *continued*

Non-PPO benefit

High Option - Assistant surgeons' fees are payable up to **20%** of the reasonable and customary allowance for the surgery.

Standard Option - After the $350 calendar year deductible has been met, the Plan pays assistant surgeons' fees up to **15%** of the reasonable and customary allowance for the surgery.

Second opinion (voluntary)

Second surgical opinions are covered under Other Medical Benefits.

Pre-surgical testing

Laboratory tests, pathology, radiology and X-rays related to surgery are paid as Other Medical Benefits (see page 19).

Anesthesia

PPO benefit

Both Options - The Plan pays **90%** of the negotiated rate (after the $200 calendar year deductible has been met for **Standard Option**).

Non-PPO benefit

High Option - The Plan pays **85%** of the reasonable and customary allowance.

Standard Option - After the $350 calendar year deductible has been met, the Plan pays **70%** of the reasonable and customary allowance.

Organ/tissue transplants and donor expenses

This benefit applies only if the recipient is covered by the Plan. A recipient is a person insured by the Plan who undergoes a surgical procedure to receive a body organ/tissue transplant. A donor is a person who undergoes a surgical procedure for the purpose of donating a body organ(s)/tissue for transplant surgery. All reasonable and customary inpatient hospital and medical charges incurred for a surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury. Plan approval is required on all related expenses prior to the surgery. The charges for procurement of cadaver organs are also based on Plan approval.

Both Options - Transplant charges will be covered up to a $100,000 maximum per transplant.

What is covered

- Cornea, bone, heart, kidney, liver, pancreas, heart/lung, single lung and double lung transplants.
- 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 cell 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.
- Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.

The Plan provides a Managed Transplant System (MTS) Program. If the member agrees to participate in this program, then charges for most of the above procedures are covered up to a maximum of $300,000 per transplant. Included in this $300,000 maximum is a travel and lodging allowance of $8,000 for the recipient and one family member. Routine aftercare provided by the transplant center and its affiliated providers for one year after the transplant is also included. The MTS Program covers the following transplants: bone marrow, heart, kidney/pancreas, liver, heart/lung, single lung and double lung transplants.

Section 5. Benefits *continued*

What is not covered

- Donor screening tests for organ transplants, except those performed for the actual donor when the recipient is covered by the Plan.
- 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 would not be medically necessary or appropriate but for the non-covered procedure.
- Islet of Langerhans, artificial heart and other transplants not listed as covered.
- Allogeneic and autologous bone marrow and stem cell transplants for solid tumors except as noted above.

Oral and maxillofacial surgery

The following procedures are covered as shown on page 14:

- Reduction of fractures of the jaw 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
- Removal of impacted teeth

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 except that removal of impactions are paid at the reasonable and customary allowance for each procedure performed. Procedures that involve teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone) are considered dental treatment rather than oral surgery. For covered dental treatment, see pages 24 through 28.

Mastectomy surgery

Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

Benefits will be provided for breast reconstruction surgery following a mastectomy, including surgery to produce a symmetrical appearance on the other breast. Benefits will be provided for all stages of breast reconstruction following a mastectomy, including treatment of any physical complications, including lymphedemas, and for breast prostheses, including surgical bras and replacements.

What is not covered

- Eye surgery, such as radial keratotomy, when the primary purpose is to correct myopia, hyperopia, or astigmatism; eye exercises and orthoptics (visual training)
- Cosmetic surgery and all related expenses except for the correction of congenital anomalies or repair following an accidental injury
- Injections of silicone, collagens and similar substances
- All procedures associated with treatment of temporomandibular disorders
- Assistant surgery services rendered by a non-physician provider such as a Physician Assistant (P.A.), Certified Registered Nurse First Assistant (C.R.N.F.A.) and Certified Surgical Technologist (C.S.T.)

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.

Section 5. Benefits *continued*

Maternity Benefits

What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary.

Inpatient hospital

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn admissions that extend beyond the mother's discharge must be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See page 38 for details.

Room and board

Plan pays room and board charges for ward, semiprivate or intensive care.

PPO benefit	**High Option** - Plan pays full charges (no deductible).	**Standard Option** - Plan pays full charges (no deductible).
	See page 9 for information on PPO hospitals.	
Non-PPO benefit	**High Option** - After a $150 per admission deductible, Plan pays full charges.	**Standard Option** - After a $250 per admission deductible, Plan pays **70%** of covered charges.

Other charges

PPO benefit	**High Option** - Plan pays **100%** of covered charges.	**Standard Option** - Plan pays **100%** of covered charges.
Non-PPO benefit	**High Option** - The Plan pays **85%** for the first 30 days, then **100%** of covered charges.	**Standard Option** - The Plan pays **70%** of covered charges.

Hospital bassinet and nursery charges for days on which both mother and child would normally be confined following delivery are considered hospital expenses of the mother, not the child. When a newborn requires definitive treatment or evaluation for medical or surgical reasons, during or after the mother's stay, the newborn is considered a patient in his or her own right and a separate per admission deductible applies. Expenses of the newborn are payable only if the child is covered under a Self and Family enrollment.

Stand-by doctor charges will be covered only if medically necessary treatment is actually rendered to the child by the doctor.

Outpatient care

Facility charges for an outpatient delivery or delivery at a birthing center are covered as outpatient surgery under Other Medical Benefits.

Obstetrical care

PPO benefit	**Both Options** - The Plan pays **90%** of the negotiated rate (after the $200 calendar year deductible has been met for **Standard Option**).	
Non-PPO benefit	**High Option** - The Plan pays **85%** of the reasonable and customary allowance.	**Standard Option** - After the $350 calendar year deductible has been met, the Plan pays **70%** of the reasonable and customary allowance.

Section 5. Benefits *continued*

Related benefits

Diagnosis and treatment of infertility — Covered under Other Medical Benefits subject to Plan approval. See page 19.

Pregnancy risk management program — Covered under Other Medical Benefits subject to Plan approval. See page 19.

Voluntary sterilization — Covered under Surgical Benefits. See page 14.

For whom — Benefits are payable under Self Only enrollments and for family members covered under Self and Family enrollments.

What is not covered

- Assisted Reproductive Technology (ART) procedures such as artificial insemination, in vitro fertilization, embryo transfer and Gamete Intrafallopian Transfer (GIFT), as well as services and supplies related to ART procedures, are not covered.
- Reversal of voluntary surgical sterilization and all related expenses

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.

Mental Conditions/Substance Abuse Benefits

What is covered — *PPO benefits do not apply to Mental Conditions/Substance Abuse Benefits. The Plan pays for the following services:*

Mental conditions

Inpatient care

High Option - After a $500 per admission deductible, the Plan pays **70%** of covered charges for inpatient room and board and other hospital charges for up to 100 days per calendar year.

Standard Option - After a $500 per admission deductible, the Plan pays **60%** of covered charges for inpatient room and board and other hospital charges for up to 100 days per calendar year.

Two admissions in the same year separated by 30 or fewer days are considered one admission and require one deductible.

Precertification — The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See page 38 for details.

Inpatient visits

High Option - After the $275 calendar year deductible, doctors inpatient services are payable at **80%** of reasonable and customary charges for services rendered during the 100 days per calendar year of covered inpatient care.

Standard Option - After the $300 per person/$600 per family mental conditions calendar year deductible, doctors inpatient services are payable at **50%** of reasonable and customary charges for services rendered during the 100 days per calendar year of covered inpatient care.

Hospital Day treatment — **Both Options** - The Plan provides benefits for day treatment, subject to the Plan's approval, limited to the Plan's inpatient benefits (See "Inpatient Care" above). Day treatment is also known as transitional care or partial hospitalization.

Section 5. Benefits *continued*

Outpatient care

High Option - After the $275 calendar year deductible, the Plan pays **50%** of reasonable and customary charges, to a maximum Plan payment of $50 per visit, for up to 25 visits per calendar year for the treatment of mental conditions.

Standard Option - After the $300 mental conditions calendar year deductible, the Plan pays **50%** of reasonable and customary charges, to a maximum Plan payment of $50 per visit, for up to 25 visits per calendar year for the treatment of mental conditions.

Visits used by the member in satisfying the deductible do not count toward the 25 visit limit.

Substance abuse

Both Options - After satisfaction of a $500 calendar year deductible, the Plan pays **70%**, up to annual maximum, of the remaining covered charges for room and board and other charges made by a hospital or rehabilitation facility for treatment of alcohol or drug abuse, including outpatient services and supplies.

Benefits for the treatment of substance abuse are limited to a maximum Plan payment of $3,500 per person per calendar year.

Precertification

Precertification requirements described above apply to all admissions for treatment of substance abuse.

What is not covered

- Treatment of learning disabilities
- Treatment related to marital discord
- Personal comfort items such as telephone and television, guest meals and beds, barber and beauty services
- Custodial care (see page 40)

Other Medical Benefits

What is covered

PPO benefit

High Option - After the $200 calendar year deductible has been met, the Plan pays **90%** of negotiated rate for the services listed on this page.

Standard Option - After the $200 calendar year deductible has been met, the Plan pays **90%** of negotiated rate for the services listed on this page except for home and office visits. After a $10 co-payment per visit, the Plan pays **100%** for home and office visits, including medical care rendered by the doctor during the visit.

Non-PPO benefit

High Option - After the $275 calendar year deductible has been met, the Plan pays **80%** of reasonable and customary charges for the following:

Standard Option - After the $350 calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges for the following:

- Home, office and hospital visits and other medical care, including office visits and tests used to monitor pharmacotherapy for mental conditions
- Hospital services: outpatient services and supplies including those related to services covered under Dental Benefits
- Anesthesia and its administration for non-surgical procedures (see page 15 for benefits in conjunction with surgery)
- Allergy treatment, serum, and injections
- Blood transfusions, including blood, plasma and blood plasma expanders
- Radiation therapy and chemotherapy
- Home IV therapy
- Diagnostic X-ray, and laboratory tests, including electrocardiogram, electroencephalogram, radioisotope, other machine testing and preadmission diagnostic testing
- Diagnosis and treatment of infertility when approved by the Plan (see page 18 for exclusions)
- Pregnancy risk management programs when approved by the Plan

Section 5. Benefits *continued*

- Renal Dialysis
- Physical, occupational and speech therapy, when prescribed by a doctor and rendered by a qualified professional therapist is payable up to a total of 40 visits under **High Option** and 24 visits under **Standard Option** per calendar year. Each type of therapy rendered is considered a separate visit. Speech therapy is payable only if services are provided to restore speech when functional loss of speech is due to disease, illness, or injury

Routine services

In addition to coverage of diagnostic X-ray, laboratory and pathology services and machine diagnostic tests, the following routine (screening) services are covered as preventive care:

Physical exams

Routine physicals, including a complete history and workup, are covered once every two years for members age 13 through 39 and once every year for those age 40 and above.

What is not covered

Physical exams for school, sports, employment or travel

Breast cancer screening

Mammograms are covered for women age 35 and older as follows:

- From age 35 through 39, one mammogram screening during this five year period
- From age 40 through 49, one mammogram screening every one or two consecutive calendar years
- From age 50 through 64, one mammogram screening every calendar year
- At age 65 or older, one mammogram screening every two consecutive calendar years

Cervical cancer screening

Annual coverage of one pap smear for women age 18 and older

Colorectal cancer screening

- Annual coverage of one fecal occult blood test for members age 40 and older
- At age 50 and older, one sigmoidoscopy every five years

Prostate cancer screening

Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older

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.

PPO benefits do not apply to Other services or Limited benefits.

Other services

- Disposable needles and syringes
- Oxygen and equipment for its administration
- Local professional ambulance service associated with covered hospital inpatient care or when related to, and within 72 hours after, an accidental injury or medical emergency or during covered home health care
- Insulin and diabetic supplies (such as needles, syringes and test materials)
- Orthopedic braces and prosthetic appliances such as artificial limbs and eyes when ordered by a doctor, including replacement when required by a change in the patient's condition, and expenses for repair and adjustment

Section 5. Benefits *continued*

Limited benefits

Nursing services and home health care

Benefits are provided for private duty nursing care performed outside the hospital by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.); and for part-time or intermittent nursing care furnished during home visits by an R.N., L.P.N., L.V.N. and home health aides that are part of a home health care plan that starts within 36 hours after discharge from a covered hospital confinement.

A doctor must certify in writing as to the (1) length of time such care is needed, (2) specific professional skills required by the patient and (3) medical necessity for the skilled service. In addition, for benefits to be paid for home visits, the doctor must certify that further inpatient care would be required if home health care were not given and the home health care plan must be coordinated by the hospital and the covered services billed for by a health care provider organization (such as a hospital or a home health care agency). The Plan may request nursing notes.

Benefits for nursing services and home health care are limited to a maximum Plan payment of $10,000 per person per calendar year.

What is not covered

Nursing care primarily for custodial care (see page 40)

Smoking cessation benefit

After satisfaction of the calendar year deductible, the Plan will pay up to $100 for enrollment in one smoking cessation program, including any related prescription drugs, per member per lifetime. Smoking cessation drugs and medications, including nicotine patches, are not available under any other Plan provisions. Benefits will be paid directly to the enrollee upon submission of a completed claim form and bill.

Supplies

The following supplies are covered under specific circumstances:

- Hearing aids, including exams and adjustments to hearing devices, if required to correct a hearing impairment caused by surgery or injury and obtained within 120 days thereof
- One pair of eyeglasses or contact lenses, including exams, if required to correct impairment directly caused by accidental ocular injury or intraocular surgery (such as removal of cataracts) and obtained within one year of the injury or surgery

What is not covered

- Eyeglasses, contact lenses (including their replacements and spares), special tinting, and related examinations and tests (except as provided above)
- Eye exercises and orthoptics (visual training)
- Sun or heat lamps; heating pads; air conditioners, purifiers and humidifiers; exercise, safety, computer, communication and convenience equipment; stair glides, ramps, liftchairs, elevators and other modifications or alterations to vehicles or households; whirlpools, saunas and similar household items
- Travel, transportation, convalescent care or rest cures
- Orthopedic and corrective shoes, arch supports, foot orthotics and other supportive foot devices; elastic stockings and support hose
- Hearing aids, and related examinations and tests (except as provided above); batteries, glasses or ocular exams if part of hearing device; repairs or replacements of hearing devices
- Services and supplies for cosmetic purposes such as Rogaine or wigs
- Chelation therapy, except for acute arsenic, gold, lead or mercury poisoning
- Maintenance cardiac rehabilitation and exercise programs

Section 5. Benefits *continued*

Additional Benefits

Accidental injury

Both Options pay **100%** of reasonable and customary charges for non-surgical outpatient treatment rendered within 72 hours of an accidental injury (see page 40).

Chiropractic services

Chiropractic treatment is payable for up to $15 per visit under **High Option**, not to exceed 25 visits per calendar year, and up to $10 per visit under **Standard Option**, not to exceed 12 visits per calendar year.

Durable medical equipment

The Plan pays **80%** under **High Option** and **70%** under **Standard Option** after a $100 copayment per device for the rental, repair and purchase of durable medical equipment. 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. (See definition on page 40)

Emergency room charges

Non-surgical medical treatment rendered in a hospital emergency room for any reason other than an accidental injury, is covered as follows:

PPO	**High Option** - The Plan pays **90%** of the negotiated rate after a $50 copay per access to care.	**Standard Option** - The Plan pays **90%** of the negotiated rate after a $50 copay per access to care.
Non-PPO	**High Option** - The Plan pays **80%** of reasonable and customary charges after a $50 copay per access to care.	**Standard Option** - The Plan pays **70%** of reasonable and customary charges after a $50 copay per access to care.

Hospice care

Both Options pay: (1) **100%** of covered charges up to $2,000 for each period of care for outpatient care from a hospice care program; (2) $150 per day up to $3,000 for each period of care for inpatient care in a hospice.

These benefits will be paid if the hospice care program begins after a person's primary doctor certifies terminal illness and life expectancy of six months or less, and if any service or inpatient hospice stay that is a part of the program is:

- 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.

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.

Bereavement benefit

Both Options pay $200 for family bereavement counseling and supportive services if the covered family members receive these 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.

Immunizations

Childhood

Both Options pay **100%** of reasonable and customary charges for childhood immunizations recommended by the American Academy of Pediatrics for dependent children under age 22.

Age 65 and over

Both Options pay **100%** of reasonable and customary charges for one annual influenza and one annual pneumoccocal vaccine.

Skilled nursing facilities

When **Medicare Part A** is primary payer (it pays first) and has made payment, **Both Options** provide secondary benefits for the applicable **Medicare Part A** copayments in full.

Section 5. Benefits *continued*

Well child care

Well child care (including blood lead level screenings and routine office visits, lab, and X-rays) for children through age 12 is payable up to $150 per child for **High Option** and up to $125 per child for **Standard Option** per calendar year.

Prescription Drug Benefits

What is covered

You may purchase the following medications and supplies prescribed by a doctor from either a pharmacy or by mail:

- Drugs that by Federal law of the United States require a doctor's prescription for their purchase
- Insulin
- Needles and syringes for the administration of covered medications
- Contraceptive drugs and devices, including Norplant

What is not covered

- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Medication that does not require a prescription under Federal law even if your doctor prescribes it or state law requires it
- Nutritional supplements; vitamins and minerals
- Drugs to aid in smoking cessation other than those covered under the Smoking cessation benefit.

From a pharmacy

The Plan will cover up to a 30-day supply of covered drugs or supplies from participating retail pharmacies or from non-participating retail pharmacies. Call Postmasters Benefit Plan at 703/683-5585 or visit our website at http://www.postmasters.org/pbp.asp to locate a participating retail pharmacy in your area.

Participating retail pharmacy

High Option - After the $50 calendar year drug deductible, you pay to the pharmacy a **$5** copayment for generic and a **$12** copayment for name brand drugs per prescription or refill. The Plan will pay the remainder of the discounted cost.

Standard Option - After the $50 calendar year drug deductible, you pay to the pharmacy a **$10** copayment for generic and a **$20** copayment for name brand drugs per prescription or refill. The Plan will pay the remainder of the discounted cost.

An ID card will be sent to each member along with a list of participating retail pharmacies. When you present the card you will be given a discount on your prescription. You must show your prescription drug card to receive the discount. There is no claim form to file.

Non-participating retail pharmacy

High Option - After the $100 calendar year drug deductible, the Plan pays **80%** of the covered charge.

Standard Option - After the $100 calendar year drug deductible, the Plan pays **70%** of the covered charge.

To claim benefits

Obtain a receipt when you use a non-participating pharmacy. Receipts must include the prescription number, name of drug, prescribing doctor's name, date, name and address of pharmacy or store where drug was purchased, the number of days the supply covers, patient's name and charge. Canceled checks or cash register receipts are not acceptable. Use a HCFA-1500 claim form to claim benefits for prescription drugs and supplies you purchase. You may obtain these forms by calling 703/683-5585. Mail it to Postmasters Benefit Plan, 1019 North Royal Street, Alexandria, VA 22314-1596.

Waiver

High Option - When Medicare Part B is the primary payer, the Plan waives the $100 calendar year drug deductible for non-participating pharmacies and pays **80%**. The Plan also waives the $50 calendar year drug deductible for participating pharmacies. The copayments of **$5** or **$12** for participating pharmacies are not waived.

Standard Option - When Medicare Part B is the primary payer, the Plan waives the $100 calendar year drug deductible for non-participating pharmacies and pays **70%**. The Plan also waives the $50 calendar year drug deductible for participating pharmacies. The copayments of **$10** and **$20** for participating pharmacies are not waived.

Section 5. Benefits *continued*

By Mail

You may purchase up to a 90-day supply of maintenance drugs through the Mail Order Drug Program. All drugs and supplies listed above are covered except for those that require constant refrigeration, are too heavy to mail, or that must be administered by doctors in a clinical setting.

Under the Mail Order Drug Program, if a generic equivalent to the prescribed drug is available, Merck-Medco Services will dispense the generic equivalent instead of the name brand unless your doctor specifies that the name brand is required.

High Option - You pay **$5** for generic and **$12** for name brand drugs.

Standard Option - After a $50 calendar year drug deductible, you pay **$10** for generic and **$20** for name brand drugs.

Waiver

High Option - When Medicare Part B is the primary payer, the Plan waives the **$5** and **$12** copayments.

Standard Option - When Medicare Part B is the primary payer, the Plan waives the $50 calendar year drug deductible and the **$10** and **$20** copayments

Prescriber's choice program

When your mail order prescription is received it will be reviewed to determine if it is a prescription that could be replaced with a more cost effective alternative medication or "preferred drug". A pharmacist will contact your doctor and identify the cost effective alternative medication that is available. If your doctor agrees to change your medication to this preferred drug at the time your prescription is filled, you will be sent a check for one half the amount of your applicable mail order drug copay.

To claim benefits

The Plan will send you information on the Mail Order Drug Program. To use the Program:

(1) Complete the initial mail order form.

(2) Enclose your prescription and copayment.

(3) Mail your order to Merck-Medco Services.

(4) Allow approximately two weeks for delivery.

You'll receive forms for refills and future prescription orders each time you receive drugs or supplies under this Program. In the meantime, if you have any questions about a particular drug or a prescription, you may call Merck-Medco Services toll-free: 1-800-631-7780. To request order forms, you may call toll-free: 1-800-631-7780 or the Plan at 1-703-683-5585.

Dental Benefits

What is covered

The Plan will pay actual charges up to the amount specified in the Schedule of dental allowances under both Standard and High Options.

Both Options

Accidental injury to teeth

The Plan pays covered charges up to the High Option Schedule of dental allowances for repair of accidental injury (see page 40) to sound natural teeth. Injury to the teeth from chewing or biting is not considered an accidental injury for purposes of this provision.

High Option

Basic services

After satisfaction of a $30 dental deductible, the Plan pays covered charges for basic services up to the applicable limit shown in the Schedule of dental allowances on pages 25 and 26.

Major services

After the $30 dental deductible the Plan pays covered charges up to a percentage of the applicable limit shown in the Schedule of dental allowances on pages 26 and 27. 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 limit; second calendar year, **75%** of scheduled limit; thereafter, **100%** of scheduled limit.

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

The following Schedule of dental allowances, for basic and major services is a complete list of covered dental services available under the High Option.

Note: The Plan pays actual charges up to the scheduled limits.

Section 5. Benefits *continued*

High Option basic services

ADA Code	Diagnostic	Scheduled Limit
0120	Periodic oral evaluation (routine exams limited to two per year)	6.50
0140	Limited oral evaluation-problem focused	6.50
0150	Comprehensive oral evaluation	9.00
0160	Detailed and extensive oral evaluation-problem focused, by report	11.00
0210	Intraoral, complete series including bitewings (limited to one every three years)	23.00
0220	Intraoral, periapical first film	3.50
0230	Intraoral, periapical each additional film	1.00
0240	Intraoral, occlusal film	6.00
0250	Extraoral, first film	7.00
0260	Extraoral, each additional film	7.00
0270	Bitewing, single film	3.50
0272	Bitewings, two films	6.50
0274	Bitewings, four films (bitewings limited to two series per year)	9.50
0330	Panoramic film (considered a complete series)	19.00
0460	Pulp vitality tests	7.00
0470	Diagnostic casts	15.50
	Preventive	
1110	Prophylaxis, adult (age 14 or over) (prophylaxes or cleanings are limited to two per year)	14.50
1120	Prophylaxis, child (under age 14) (prophylaxes or cleanings are limited to two per year)	10.50
1201	Topical application of fluoride, including prophylaxis	17.00
1203	Topical application of fluoride, prophylaxis not included (applications of fluoride, limited to one per year and to children under age 14)	6.50
1510	Space maintainer, fixed, unilateral	77.50
1515	Space maintainer, fixed, bilateral	77.50
1520	Space maintainer, removable, unilateral	113.50
1525	Space maintainer, removable, bilateral	113.50
1550	Recementation of space maintainer (space maintainers are passive appliances, schedule limit includes all adjustments)	10.00
	Restorative	
	Note: Multiple restorations on one surface will be considered as a single restoration.	
2110	Amalgam, one surface, primary	13.50
2120	Amalgam, two surfaces, primary	19.50
2130	Amalgam, three surfaces, primary	25.00
2140	Amalgam, one surface, permanent	14.50
2150	Amalgam, two surfaces, permanent	22.00
2160	Amalgam, three surfaces, permanent	29.50
2210	Silicate cement	18.00
2330	Resin, one surface	17.00
2331	Resin, two surfaces	24.00
2332	Resin, three surfaces	29.50
2951	Pin retention, per tooth in addition to restoration	10.50

ADA Code	Endodontics	Scheduled Limit
3110	Pulp cap, direct	9.50
3120	Pulp cap, indirect	9.50
3220	Therapeutic pulpotomy	17.50
3310	Root canal, one	108.00
3320	Root canal, two	131.00
3330	Root canal, three or more	178.50
3351	Apexification /recalcification-initial visit	7.00
3410	Apicoectomy/periradicular surgery-anterior	113.00
	Periodontics	
4210	Gingivectomy or gingivoplasty, per quadrant	86.00
4211	Gingivectomy or gingivoplasty, per tooth	22.00
4220	Gingival curettage, surgical, per quadrant, by report	12.00
4240	Gingival flap procedure including root planing, per quadrant	33.50
4249	Clinical crown lengthening-hard tissue	90.00
4260	Osseous surgery (including flap entry and closure) per quadrant	194.00
4263	Bone replacement graft-first site in quadrant	84.00
4271	Free soft tissue, graft procedure (including donor site surgery)	142.00
4320	Provisional splinting, intracoronal	33.50
4321	Provisional splinting, extracoronal	35.50
4341	Periodontal scaling and root planing, per quadrant	15.00
4910	Periodontal maintenance procedures (following active therapy)	19.50
	Prosthodontics (removable) repairs	
5510	Repair broken complete denture base	26.00
5520	Replace missing or broken teeth, complete denture (each tooth)	5.00
5610	Repair resin denture base	25.00
5620	Repair cast framework	34.00
5630	Repair or replace broken clasp	20.00
5640	Replace broken teeth, per tooth	5.00
5650	Add tooth to existing partial denture	11.00
5660	Add clasp to existing partial denture	24.00
	Oral surgery (includes local anesthesia and routine postoperative care)	
7110	Extraction, single tooth	17.00
7120	Extraction, each additional tooth	14.50
7130	Root removal, exposed roots	18.00
7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	24.00
7250	Surgical removal of residual tooth roots (cutting procedure)	28.50
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	46.50
7310	Alveoloplasty in conjunction with extractions per quadrant	30.50
7320	Alveoloplasty not in conjunction with extractions per quadrant	49.50

Section 5. Benefits *continued*

High Option basic services *continued*

ADA Code	Oral surgery *continued*	Scheduled Limit
7450	Removal of odontogenic cyst or tumor, lesion diameter up to 1.25 cm	42.00
7451	Removal of odontogenic cyst or tumor, lesion diameter over 1.25 cm	94.50
7510	Incision and drainage of abscess, intraoral soft tissue	24.50
7520	Incision and drainage of abscess, extraoral soft tissue	24.50
7970	Excision of hyperplastic tissue, per arch	67.00
7971	Excision of pericoronal gingiva	28.50
	Adjunctive general services	
9220	General anesthesia	45.00
9230	Analgesia	9.00
9240	Intravenous sedation	43.00
9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	18.00
9430	Office visit for observation (during regularly scheduled hours)	6.50
9440	Office visit, after regularly scheduled hours	8.00
9950	Occlusion analysis, mounted case	17.50
9951	Occlusal adjustment, limited	25.00
9952	Occlusal adjustment, complete	110.00

High Option major services

ADA Code	Restorative	Scheduled Limit
2410	Gold foil, one surface	$24.50
2420	Gold foil, two surfaces	53.50
2430	Gold foil, three surfaces	74.50
2510	Inlay, metallic, one surface	40.00
2520	Inlay, metallic, two surfaces	92.50
2530	Inlay, metallic, three or more surfaces	117.50
2610	Inlay, porcelain/ceramic, one surface	24.50
2620	Inlay, porcelain/ceramic, two surfaces	45.00
2630	Inlay, porcelain/ceramic, three or more surfaces	69.00
2710	Crown, resin (laboratory)	73.50
2720	Crown, resin with high noble metal	198.50
2721	Crown, resin with predominantly base metal	167.00
2722	Crown, resin with noble metal	182.50
2740	Crown, porcelain/ceramic substrate	184.00
2750	Crown, porcelain fused to high noble metal	215.50
2751	Crown, porcelain fused to predominantly base metal	184.00
2752	Crown, porcelain fused to noble metal	199.50
2790	Crown, full cast high noble metal	203.50
2791	Crown, full cast predominantly base metal	172.00
2792	Crown, full cast noble metal	188.00
2810	Crown, 3/4 cast metallic	198.50
2910	Recement inlay	11.50
2920	Recement crown	11.50
2930-31	Prefabricated stainless steel crown primary or permanent tooth	40.00
2932	Prefabricated resin crown	40.00
2940	Sedative filling	8.00
2950	Core buildup including any pins	2.00
2952	Cast post and core in addition to crown	56.50
2954	Prefabricated post and core in addition to crown	32.00
2970	Temporary crown (fractured tooth)	40.00
	Prosthodontics (removable)	
5110-20	Complete upper or lower denture	242.50
5130-40	Immediate upper or lower denture	275.00
5211	Maxillary partial denture-resin (including any conventional clasps, rest and teeth)	237.50
5212	Mandibular partial denture-resin base (including any conventional clasps, rest and teeth)	237.50
5213	Maxillary partial denture-cast metal framework with resindenture bases (including any conventional clasps and teeth)	271.00
5214	Mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	271.00
5281	Removable unilateral partial denture-one piece cast metal (including clasp and teeth)	157.50
5410-11	Adjust complete upper or lower denture	17.00
5421-22	Adjust partial upper or lower denture	17.00
5710-11	Rebase complete denture	94.50
5720-21	Rebase partial denture	71.00
5730-31	Reline complete denture (chairside)	56.50
5740-41	Reline partial denture (chairside)	43.00
5750-51	Reline complete denture (laboratory)	76.00
5760-61	Reline partial denture (laboratory)	65.00
5810-11	Interim complete denture	115.50
5820-21	Interim partial denture	65.00
5850	Tissue conditioning per denture unit	20.00
5860	Overdenture, complete, by report	350.00
5861	Overdenture, partial ,by report	280.00
5862	Precision attachment, by report	98.00
	Prosthodontics (fixed)	
6210	Pontic, cast high noble metal	204.00
6211	Pontic, cast predominantly base metal	172.00
6212	Pontic, cast noble metal	188.00
6240	Pontic, porcelain fused to high noble metal	215.50
6241	Pontic, porcelain fused to predominantly base metal	184.00

Section 5. Benefits *continued*

High Option major services *continued*

ADA Code	Prosthondontics (fixed) *continued*	Scheduled Limit
6242	Pontic, porcelain fused to noble metal	199.50
6250	Pontic, resin with high noble metal	222.00
6251	Pontic, resin with predominantly base metal	175.00
6252	Pontic, resin with noble metal	197.00
6520	Inlay, metallic two surfaces	92.50
6530	Inlay, metallic three or more surfaces	117.50
6545	Retainer-Cast metal for resin bonded fixed prosthetics	34.00
6720	Crown, resin with high noble metal	215.50
6721	Crown, resin with predominantly base metal	184.00
6722	Crown, resin with noble metal	199.50
6750	Crown, porcelain fused to high noble metal	234.00
6751	Crown, porcelain fused to predominantly base metal	185.00
6752	Crown, porcelain fused to noble metal	205.00
6780	Crown, 3/4 cast high noble metal	198.50
6790	Crown, full cast high noble metal	209.00
6791	Crown, full cast predominantly base metal	187.00
6792	Crown, full cast noble metal	185.00
6930	Recement fixed partial denture	21.00
6940	Stress breaker	56.50
6950	Precision attachment	92.50
6970	Cast post and core in addition to fixed partial denture retainer	66.00
6971	Cast post as part of fixed partial denture retainer	51.00
6972	Prefabricated post and core in addition to fixed partial denture retainer	37.00

Standard Option

The Plan covers charges up to the applicable limit shown in the following Schedule of dental allowances. There is no calendar year maximum or deductible. This is a complete list of covered services.

ADA Code	Diagnostic	Scheduled Limit
0120	Periodic oral evaluation (routine limited to two per year)	6.50
0140	Limited oral evaluation -problem focused	6.50
0150	Comprehensive oral evaluation	9.00
0210	Intraoral, complete series including bitewings (limited to one every three years)	15.00
0220	Intraoral, periapical, first film	1.00
0230	Intraoral, periapical, each additional film	1.00
0240	Intraoral, occlusal film	7.50
0270	Bitewing, single film	3.00
0272	Bitewings, two films	4.00
0274	Bitewings, four films (bitewings limited to two series per year)	6.50
0330	Panoramic film (considered a complete series)	15.00
	Preventive	
1110	Prophylaxis, adult (age 14 or over) (prophylaxes or cleanings are limited to two per year)	10.50
1120	Prophylaxis, child (under age 14) (prophylaxes, or cleanings, limited to two per year)	10.50
1201	Topical application of fluoride, including prophylaxis	16.00
1203	Topical application of fluoride, prophylaxis not included (application of fluoride limited to one per year and to children under age 14)	5.50
	Restorative	
	Note: Multiple restorations in one surface will be considered as a single restoration.	
2110	Amalgam, one surface, primary	11.50
2120	Amalgam, two surfaces, primary	16.50
2130	Amalgam, three surfaces, primary	22.00
2140	Amalgam, one surface, permanent	11.50
2150	Amalgam, two surfaces, permanent	18.00
2160	Amalgam, three surfaces, permanent	22.00
2210	Silicate cement	16.50
2330	Resin, one surface	11.50
2331	Resin, two surfaces	18.00
2332	Resin, three surfaces	22.00

Section 5. Benefits *continued*

Standard Option *continued*

ADA Code	Oral surgery	Scheduled Limit
7110	Extraction, single tooth	12.50
7120	Extraction, each additional tooth	7.50
7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	19.00

Related benefit

Oral and maxillofacial surgery

For covered oral and maxillofacial surgery, see page 16.

What is 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 in an accredited school of dentistry
- Dental services and supplies for which other benefits are payable under this Plan
- 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

Non-FEHB Benefits Available to Plan Members

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

Long term care

What would happen if you suddenly required nursing home care? The League offers immediate care without the red tape. Benefits are paid in addition to what you may qualify for through Medicare's "skilled" nursing home benefits. Premiums remain the same regardless of your age. For current information, please call 1-800-321-0102.

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.

Eyewear program

Outlook Vision Services Program offers you and your entire family all the saving advantages available only to Outlook Vision Services members. Outlook Vision Services offers a choice of over **6000 Professional Vision Care Providers** in all **50 States and Puerto Rico**. The Network is comprised of well-known national and regional vision care centers, independent optometrists or opticians such as most:

JC Penney Optical, Montgomery Ward, Royal Optical, Sears, Pearl Vision, For Eyes Only, Sterling Optical, Eye Masters and many more.

Best of all, as a member, you can save up to **50%** off the retail price of:

Prescription Glasses and Sunglasses
Choose from all frames in stock!

Contact Lenses (even Mail Order!)

Nonprescription Sunglasses

Accessories

Members will be able to purchase what they want, where they want, and at a very reasonable price. For more information, contact Outlook Vision Services at:

Guardian Eagle Corporation
P. O. Box 84415
Sioux Falls, SD 57118

Customer Service: **1-800-342-7188**

Non-FEHBP Benefits are not part of the FEHB contract

Section 6. How to File a Claim

Claim forms, identification cards and questions

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier at 703/683-5585 to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you have a question concerning Plan benefits, contact the Carrier at 703/683-5585 or you may write the Carrier at 1019 North Royal Street, Alexandria, VA 22314-1596.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with providers.

How to file claims

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA-1500, Health Insurance Claim Form. The claim form must be signed to authorize release of medical information and assignment of benefits. A "Signature on File" is acceptable. Claims submitted by enrollees may be submitted on the HCFA 1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee
- Plan identification number of enrollee
- Name and address of person or firm providing the service or supply
- Provider's tax identification number (needed for assigned claims and PPO providers)
- Dates that services or supplies were furnished
- Type of each service or supply and the charge
- Diagnosis

In addition:

- All requests for additional information needed by the Plan should be responded to promptly.
- For claims under Other Medical Benefits, the attending doctor must complete a doctor's statement.
- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- Bills for private duty nurses 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 doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.
- For dental claims, complete the member's section of the claim form and give it to the dentist to complete the remainder.
- For prescription drug claims, see pages 23 and 24.

Canceled checks, cash register receipts or balance due statements are not acceptable.

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

Postmasters Benefit Plan
1019 North Royal Street
Alexandria, VA 22314-1596
Telephone 703/683-5585

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. The Carrier will not provide duplicate or year end statements.

Section 6. How to File a Claim *continued*

Submit claims promptly

When covered expenses exceed the deductible, complete a claim form, attach itemized bills, and send them to the Plan. Claims for out-of-hospital benefits should not be submitted more often than quarterly. To avoid denial, all claims must be submitted no later than December 31 of the calendar year after the year in which the covered service was provided, unless timely filing was prevented by administrative operations of Government or legal incapacitation, provided the claim was submitted as soon as reasonably possible. If the Plan returns a claim or part of a claim for additional information, it must be resubmitted within 90 days, or before the timely filing period expires, whichever is later. Once benefits have been paid, there is a three year limitation on the reissuance of uncashed checks.

Direct payment to hospital or provider of care

To authorize direct payment to a hospital, doctor, or dentist, complete the authorization on the claim form or on the assignment form furnished by the hospital, doctor, or dentist.

When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available.

Privacy Act statement

If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of OPM's decision on the disputed claim.

Section 7. General exclusions — Things we don't cover

The exclusions in this section apply to all benefits. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions. 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 or condition. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Procedures, services, drugs and supplies related to sex transformations**,** sexual dysfunction or sexual inadequacy;
- Services or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses you incurred while you were not enrolled in this Plan;
- Charges that would not be made if the covered individual had no health insurance coverage;
- Services furnished without charge (except as described on page 36); 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 a 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, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 37), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge see page 35), or State premium taxes however applied;
- Routine preventive care, immunizations and all related expenses except as provided on pages 19, 20 and 22;
- Treatment for weight control or reduction (except morbid obesity);
- Social, recreational and educational services or training;
- Treatment of corns, calluses and foot subluxations;
- Therapy for developmental delays, learning disabilities, stuttering, tongue thrusting or deviate swallowing;
- Treatment of temporomandibular joint disorder;
- Services rendered by Christian Scientist providers (including sanitoriums);
- 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 this Plan; and
- Interest, completion of claim forms, or similar administrative charges made by providers.

Section 8. Limitations — Rules that affect your benefits

All benefits are subject to the definitions, limitations and exclusions in this brochure. Coverage is provided only for services and supplies that are listed in this brochure.

Medicare

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

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

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

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

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

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office, or call SSA at 1-800/638-6833.

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect primary/secondary status of this Plan and Medicare (see pages 35-36).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

The following rules apply to enrollees and their family members who are entitled to benefits from both a FEHB Plan and Medicare.

This Plan is primary if:

1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;
3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Section 8. Limitations — Rules that affect your benefits *continued*

Medicare is primary if:

1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;
5) You are enrolled in Part B only, regardless of your employment status;
6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Part A and B);
7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;
8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

When Medicare is primary

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

Inpatient Hospital Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.

Surgical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance applicable to surgical and medical care.

Mental Conditions/Substance Abuse Benefits: If you are enrolled in Medicare Part A, the Plan waives the inpatient deductible and coinsurance for hospital charges. If you are enrolled in Medicare Part B, the Plan waives the deductible and coinsurance for doctors' inpatient services and outpatient care.

Other Medical Benefits: If you are enrolled in Medicare Part B, the Plan waives the calendar year deductible and coinsurance.

Prescription Drug Benefits: If you are enrolled in Medicare Part B, the Plan waives the Prescription Drug deductibles for retail pharmacies. The coinsurance for non-participating pharmacies is not waived. The copayments for participating retail pharmacies are not waived. The Mail Order Drug Program copayments are waived for both options. The Mail Order Drug deductible is also waived for Standard Option.

Additional Benefits: If you are enrolled in Medicare Part B, the Plan waives the $100 copayment for Durable Medical Equipment and the $50 copayment and coinsurance for Emergency Room Treatment.

Dental Benefits: The deductible is not waived.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its 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 enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

Section 8. Limitations — Rules that affect your benefits *continued*

When you also enroll in a Medicare prepaid plan

When you are enrolled in a Medicare prepaid plan while you are a member of this Plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims.

Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Doctors who participate with Medicare accept assignment; that is, they have agreed not to bill you for more than the Medicare-approved amount for covered services. Some doctors who do not participate with Medicare accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid, only when the Medicare and Plan payments combined do not total the Medicare-approved amount.

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the limiting charge, is 115 percent of the Medicare-approved amount. Under this law, if you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid only if the Medicare and Plan payments combined do not total the limiting charge. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. The Medicare Summary Notice (MSN) form will have more information about this limit.

If your doctor does not participate with Medicare, asks you to pay more than the limiting charge and he or she is under contract with this Plan, call the Plan. If your doctor is not a Plan doctor, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the Medicare MSN form. In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115 percent of the Medicare-approved amount.

Medicare HMO's

If you are enrolled in a Medicare HMO and obtain care from a non-HMO provider and the HMO will not pay for the care, the Plan will base allowable charges on the Medicare limiting charge and apply the appropriate deductibles and pay regular benefits.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is primary if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. After Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses. To be sure your claims are processed by this Carrier, you must submit the MSN form from Medicare and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare MSN.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Other group insurance coverage

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

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

If we pay second, we will determine how much of the charge we will pay. After the first Plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge.

Section 8. Limitations — Rules that affect your benefits *continued*

When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

Remember: If you have double coverage, you must tell us that you have double coverage. If we determine that we are secondary, we must have a copy of the primary Plan's explanation of benefits (EOB) before we can determine how much we will pay.

When others are responsible for injuries

Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation means the Plan's right to recover any payments made to you or a family member by a third party's insurer, because of an injury or illness caused by a third party. Third party means another person or organization. If, as a result of an illness or injury for which the Plan has paid or may pay benefits, you institute a suit or claim against a third party, the Plan will take an assignment from you of the money damages paid or payable to you by any third party on the suit or claim. This means the Plan will assert a lien against any monies you receive as a result of your claim regardless of the year instituted, whether you receive money by court order or as an out-of-court settlement or any other type of settlement. The lien will apply to money proceeds in the full amount of the Plan benefits paid or payable to you or any covered member of your family, and it will act only to reimburse the Plan for its payment of such benefits.

Upon notification, the Plan will provide you with the necessary forms and will insist on execution of the assignment before paying any benefits on account of the injury or illness. Failure to notify the Plan promptly that you have instituted such a suit or claim against a third party may result in an overpayment of benefits by the Plan that is subject to recoupment. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

TRICARE

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

Workers' compensation

We do not cover services that:

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

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

The Plan is entitled to be reimbursed by OWCP (or similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

Medicaid

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

Other Government Agencies

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

DVA facilities, DoD facilities, and Indian Health Services

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 2001 or later years, and does not have a right to benefits available prior to 2000 unless those benefits are contained in this brochure.

Section 8. Limitations — Rules that affect your benefits *continued*

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in these following paragraphs applies to you when 1) you are not covered by either **Medicare Part A** (hospital insurance) or **Part B** (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by **Medicare Part A**, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had **Medicare Part A**. This amount is called the equivalent Medicare amount. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 703/683-5585 for assistance.

Physician services

Claims for physician services provided for retired FEHB members, age 65 and older who do not have Medicare Part B are also processed in accordance with 5 USC 8904 (b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the Medicare-approved amount (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your doctor is a member of the Plan's preferred provider organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO doctor who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, unless the doctor's agreement with the Carrier specifies otherwise, you must pay the difference between the Medicare-approved amount and the limiting charge (115% of the Medicare-approved amount).

If your physician is not a Plan PPO doctor but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's high option surgery benefit, the Plan will pay 85% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 15% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, and any balance, up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 703/683-5585 for assistance.

Section 9. FFS facts

Precertification

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. It is your responsibility to ensure that precertification is obtained. If Precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500.

To precertify a scheduled admission:

- You, your representative, your doctor or your hospital must call, First Health Group Corp., prior to admission. The toll-free number is 1-800-654-6530.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization; proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

First Health Group Corp., will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Carrier's precertification decision will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Need additional days?

If any additional days are required, your doctor or the hospital must call the above number and request certification of additional days. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to not be medically necessary by the Carrier during the claim review.

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital stay (see pages 33-35). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States and Puerto Rico.

Maternity or emergency admissions

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 1-800-654-6530 within two business days following the day of admission, even if the patient has been discharged from the hospital. If not, inpatient benefits otherwise payable for the admission will be reduced by $500.

Newborn admissions that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued stay within two business days following the day of the mother's discharge.

Other considerations

An early determination of need for admission (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless the Carrier is misled by the information given to it. After the claim is received, the Carrier will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If you do not precertify

If precertification is not obtained before admission to the hospital (or within two business days following the day of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary, the inpatient hospital benefits will not be paid. However, medical supplies and services otherwise payable on an outpatient basis will be paid.

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by $500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the stay that was not medically necessary. However, medical services and supplies otherwise payable on an outpatient basis will be paid.

Section 9. FFS facts *continued*

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling us at 703/683-5585, visit our website at http://www.postmaster.org/pbp.asp or you may write us at 1019 North Royal Street, Alexandria, VA 22314-1596.

Information that must be made available to you includes:

- Disenrollment rates for 1998.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Catastrophic protection

For those services with coinsurance, other than prescription drug services, the Plan pays **100%** of reasonable and customary charges for the remainder of the calendar year after out-of-pocket expenses for the coinsurances and deductible shown below for that calendar year exceed $2,500 under **High Option** and $4,500 ($3,000 if using PPO providers) under **Standard Option** for you and any covered family members.

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

High Option

- The 20% you pay for Other Medical Benefits or 10% if using a PPO;
- The 20% you pay for Emergency Room Treatment or 10% if using a PPO;
- The 15% you pay for Inpatient Hospital Benefits;
- The 15% you pay for Surgical benefits or 10% if using a PPO;
- The $200 (PPO) and $275 (Non-PPO) calendar year deductible; and
- The 20% you pay for Durable Medical Equipment.

Standard Option

- The 30% you pay for Other Medical Benefits 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 Inpatient Hospital Benefits;
- The 30% you pay for Surgical benefits or 10% if using a PPO;
- The $200 (PPO) and $350 (Non-PPO) calendar year deductible; and
- The 30% you pay for Durable Medical Equipment.

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

- Copayments
- Prescription drug expenses.
- Expenses in excess of reasonable and customary allowances or maximum benefit limitations;
- Expenses for mental conditions, substance abuse or dental care and the inpatient hospital deductible; and
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see page 38).

Carryover

If you changed to this Plan during open season from a Plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that Plan's catastrophic protection benefit during the prior year will be covered by your old Plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you already met the covered out-of-pocket maximum expense level in full, your old Plan's catastrophic protection benefit will continue to apply until the effective date. If you have not met this expense level in full, your old Plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date. The old Plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Section 9. FFS facts *continued*

Definitions

Accidental injury

An injury caused by an external force or element such as a blow or fall that requires immediate medical attention. Also included are animal bites, poisonings, and dental care required to repair injuries to sound natural teeth as a result of an accidental injury, not from biting or chewing.

Admission

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

Assignment

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

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes and other conditions that the Carrier 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 respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

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 an illness or injury;
(5) is designed for prolonged use; and
(6) serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

The date the benefits described in this brochure are effective:

(1) January 1 for continuing enrollments and for all annuitant enrollments;
(2) the first day of the first full pay period of the new year for enrollees who change Plans or options or elect FEHB coverage during the open season for the first time; or
(3) for new enrollees during the calendar year, but not during the open season, the effective date of enrollment as determined by the employing office or retirement system.

Section 9. FFS facts *continued*

Experimental or investigational

See definition on page 10.

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.).

Hospice care program

A formal program directed by a doctor to help care for the terminally ill through either: (1) a centrally administered, medically directed and nurse coordinated program that provides a coherent system of home care; uses a hospice team; and is available 24 hours a day; or (2) confinement of the terminally ill person in a hospice. The hospice team must include a doctor and registered nurse (R.N.) and may include social workers, clergymen/counselors, volunteers, clinical psychologists and physical or occupational therapists.

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 emergency

The sudden and unexpected onset of a condition requiring immediate medical care, which the covered person secures within 72 hours after the onset. The severity of the condition, as revealed by the doctor's diagnosis, must be such as would normally require emergency care. Medical emergencies include heart attacks, strokes, loss of consciousness or respiration, convulsions, and such other acute conditions as may be determined by the Plan to be medical emergencies.

Medically necessary

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

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

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically 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 the Carrier; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

Morbid obesity

A condition in which an individual weighs the greater of 100 pounds or 100% over his or her normal weight.

Section 9. FFS facts *continued*

Reasonable and customary

The prevailing charge in a geographic area made by other providers for the treatment of an illness or injury of comparable severity and nature. Benefits are based on, and limited to, expenses that are reasonable and customary as determined by statistical profiles developed by Ingenix, Inc. These profiles are updated once per year. The 80th percentile of the Ingenix, Inc. is used in determining the benefits available for all surgical, anesthesia, medical and mental health care. Any amount above the Plan's allowance is the patient's responsibility.

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.

Section 10. FEHB Facts

You have the right to the following information.

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

If you want specific information about us, call 703/683-5585, or write to Postmasters Benefit Plan, 1019 North Royal Street, Alexandria, VA 22314-1596. You may also contact us by fax at 703/683-2937, or visit our website at www.postmasters.org/pbp.asp.

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

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

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

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

When are my benefits and premiums effective?

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

What happens when I retire?

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

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

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

Section 10. FEHB Facts *continued*

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

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

If you or one of your family members is covered under one FEHB Plan, that person may not receive benefits under any other FEHB Plan.

Are my medical and claims records confidential?

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

- OPM, this Plan, and our 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 subrogation 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 when the information provided does not disclose your identity,
- OPM, when reviewing a disputed claim or defending litigation about a claim,
- This Plan, as part of our administration of the prescription drug benefits, may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies, or
- This Plan reserves the right to disclose medical claim, prescription drug and laboratory data to any subcontractor engaged in medical management programs or any other program designed to help the Plan measure healthcare quality and customer satisfaction on behalf of the Carrier. All subcontractors must agree to the confidentiality provisions of this brochure and will use this data solely for the purpose of administering medical management programs that ensure participants in the program receive quality healthcare services.

Information for new members

Identification cards

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

What if I paid a deductible under my old Plan?

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

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan ends?

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

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

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

Section 10. FEHB Facts *continued*

What is former spouse coverage?

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

What is TCC?

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

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

Key points about TCC:

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

How do I enroll in TCC?

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

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

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

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

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

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

How can I convert to individual coverage?

You may convert to an individual policy if:

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

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

Section 10. FEHB Facts *continued*

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

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

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

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

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Program Demonstration Project?

The National Defense Authorization Act for 1999, Public Law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set-up some special procedures to successfully 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 FEHB. 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 eight 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.

Where are the demonstration areas?

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

When Can I Join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. 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 the 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

If you become eligible for the DoD/FEHBP Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

Department of Defense/FEHB Demonstration Project *continued*

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 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project," on the OPM web site at **www.opm.gov**.

Am I eligible for Temporary Continuation of Coverage (TCC)?

See Section 10, FEHB Facts, for information about TCC. Under this 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/FEHBP 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/FEHBP Demonstration Project.

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

Do I have the 31-Day Extension and Right To Convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

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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 703/683-5585 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

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

Penalties for Fraud

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

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

Your agency may also take administrative action against you.

Notes

Index

Summary of Benefits for Postmasters Benefit Plan - High Option – 2000

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $200 (PPO) or $275 (Non-PPO) calendar year deductible. This Plan has two options; a summary of benefits for the Standard Option is located on page 51 of this brochure.

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	**PPO benefit: 100%** of hospital room and board, no deductible applies; 100% of other covered hospital charges **Non-PPO benefit:** After a $150 per admission deductible, **100%** of hospital room and board; **85%** of other covered hospital charges for first 30 days, then **100%**.	13-14
	Surgical	**PPO benefit: 90%** of the surgeon's negotiated rate **Non-PPO benefit: 85%** of reasonable and customary allowance	14-16
	Medical	**PPO benefit: 90%*** of negotiated rate **Non-PPO benefit: 80%*** of reasonable and customary charges	19-21
	Maternity	Same benefits as for illness or injury	17-18
	Mental conditions	After a $500 per admission deductible, **70%** of hospital room and board and other hospital expenses for up to 100 days per calendar year; day treatment benefit available	18-19
	Substance abuse	After a $500 annual deductible, **70%** of covered inpatient and outpatient charges to a calendar year maximum of $3,500	19
Outpatient care	**Hospital**	**PPO benefit: 90%*** of covered charges **Non-PPO benefit: 80%*** of covered charges	19-21
	Surgical	**PPO benefit: 90%** of the surgeon's negotiated rate **Non-PPO benefit: 85%** of reasonable and customary allowance	14-16
	Medical	**PPO benefit: 90%*** of negotiated rate **Non-PPO benefit: 80%*** of reasonable and customary charges	19-21
	Maternity	Same benefits as for illness or injury	17-18
	Home health care	**80%*** of covered charges by nurses and health care agencies to a calendar year maximum of $10,000	21
	Mental conditions	**50%*** of reasonable and customary charges up to $50 per visit for 25 visits per calendar year	18-19
	Substance abuse	After a $500 annual deductible, **70%** of covered inpatient and outpatient charges to a calendar year maximum of $3,500	19
Emergency care (accidental injury)		Up to **100%** of reasonable and customary charges per accident for non-surgical outpatient treatment rendered within 72 hours of an accident	22
Prescription drugs (per prescription or refill)		Mail order drug program: Member pays $5 for generic and $12 for name brand - up to a 90-day supply	24
		Participating pharmacies: After a $50 drug deductible, member pays $5 for generic and $12 for name brand drugs - up to a 30-day supply	23
		Non-participating pharmacies: After a $100 drug deductible, Plan pays **80%** of covered charges - up to a 30-day supply	23
Dental care		After a $30 calendar year deductible, basic and major services up to $800 per person, $2,000 per family per calendar year; based on Schedule of dental allowances	24-27
Additional benefits		Chiropractic services; Hospice care; Immunizations; Skilled nursing facility; Well child care; Durable medical equipment; and Emergency room treatment	22-23
Protection against catastrophic costs		**100%** of reasonable and customary charges after the $200 (PPO) $275 (Non-PPO) calendar year deductible and eligible out-of-pocket expenses exceed $2,500 per person or family in a calendar year	39

Summary of Benefits for Postmasters Benefit Plan - Standard Option – 2000

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $200 (PPO) or $350 (Non-PPO) calendar year deductible. This Plan has two options; a summary of benefits for the High Option is located on page 50 of this brochure.

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	**PPO benefit: 100%** of hospital room and board, no deductible applies; **100%** of other covered hospital charges **Non-PPO benefit:** After a $250 per admission deductible, **70%** of hospital room and board; **70%** of other covered hospital charges	13-14
	Surgical	**PPO benefit: 90%*** of the surgeon's negotiated rate **Non-PPO benefit: 70%*** of reasonable and customary allowance	14-16
	Medical	**PPO benefit: 90%*** of negotiated rate **Non-PPO benefit: 70%*** of reasonable and customary charges	19-21
	Maternity	Same benefits as for illness or injury	17-18
	Mental conditions	After a $500 per admission deductible, **60%** of hospital room and board and other hospital expenses for up to 100 days per calendar year; day treatment benefit available	18-19
	Substance abuse	After a $500 annual deductible, **70%** of covered inpatient and outpatient charges to a calendar year maximum of $3,500	19
Outpatient care	**Hospital**	**PPO benefit: 90%*** of covered charges **Non-PPO benefit: 70%*** of covered charges	19-21
	Surgical	**PPO benefit: 90%*** of the surgeon's negotiated rate **Non-PPO benefit: 70%*** of reasonable and customary allowance	14-16
	Medical	**PPO benefit: 90%*** of negotiated rate, $10 copayment per office visit **Non-PPO benefit: 70%*** of reasonable and customary charges	19-21
	Maternity	Same benefits as for illness or injury	17-18
	Home health care	**70%*** of covered charges by nurses and health care agencies to a calendar year maximum of $10,000	21
	Mental conditions	After a $300 annual deductible, **50%** of reasonable and customary charges up to $50 per visit for 25 visits per calendar year	18-19
	Substance abuse	After a $500 annual deductible, **70%** of covered inpatient and outpatient charges to a calendar year maximum of $3,500	19
Emergency care (accidental injury)		Up to **100%** of reasonable and customary charges per accident for non-surgical outpatient treatment rendered within 72 hours of an accident	22
Prescription drugs (per prescription or refill)		Mail order drug program: After a $50 drug deductible, member pays $10 for generic and $20 for name brand drugs - up to a 90-day supply	24
		Participating pharmacies: After a $50 drug deductible member pays $10 for generic and $20 for name brand drugs - up to a 30-day supply	23
		Non-participating pharmacies: After a $100 deductible, Plan pays **70%** of covered charges - up to a 30-day supply	23
Dental care		Benefits based on Schedule of dental allowances; no annual maximums	27-28
Additional benefits		Chiropractic services; Hospice care; Immunizations; Skilled nursing facility; Well child care; Durable medical equipment; and Emergency room treatment	22-23
Protection against catastrophic costs		**100%** of reasonable and customary charges after the $200 (PPO) $350 (Non-PPO) calendar year deductible and eligible out-of-pocket expenses exceed $4,500 ($3,000 if using PPO providers) per person or family in a calendar year	39

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United States Office of Personnel Management

Federal Employees Health Benefits Program

2000 Rate Information for Postmasters Benefit Plan

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

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

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

		Non-Postal Premiumn				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
High Option Self Only	**361**	**$ 78.83**	**$122.15**	**$170.80**	**$264.66**	**$ 93.06**	**$107.92**	**$ 93.26**	**$107.72**
High Option Self and Family	**362**	**$175.97**	**$257.67**	**$381.27**	**$558.28**	**$207.74**	**$225.90**	**$201.02**	**$232.62**
Standard Option Self Only	**364**	**$ 78.83**	**$ 43.61**	**$170.80**	**$ 94.49**	**$ 93.06**	**$ 29.38**	**$ 93.26**	**$ 29.18**
Standard Option Self and Family	**365**	**$175.97**	**$ 88.89**	**$381.27**	**$192.59**	**$207.74**	**$ 57.12**	**$201.02**	**$ 63.84**