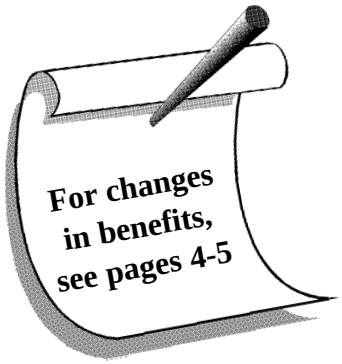
Mail Handlers Benefit Plan 2000

A Fee-for-Service Plan with a Preferred Provider Organization

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



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

To become an associate member: You may become an associate member by enrolling in this Plan. There is no membership charge for members of the National Postal Mail Handlers Union, a Division of LIUNA, AFL-CIO.

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

Enrollment codes for this Plan:

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

Visit the OPM website at http://www.opm.gov/insure
and
our website at http://www.mhbp.com

Authorized for distribution by the:

UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE

Federal Employees
Health Benefits Program

Table of Contents

Introduction

Mail Handlers Benefit Plan

This brochure describes the benefits you can receive from the Mail Handlers Benefit Plan. The National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO, has entered into contract CS 1146 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law, to offer this Plan. This Plan is underwritten by Continental Assurance 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 pages 4–5. 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 communications 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 Mail Handlers 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 or services 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 Preauthorization? This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. 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 definitions 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 (FFS) 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. This arrangement with health care providers gives you enhanced benefits or limits your out-of-pocket expenses.

Section 2. How We Change for 2000

Program-Wide Changes

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 specialty provider 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 specialty provider's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialty provider's services after the 90 day period expires.

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

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

Three states are added to the list of medically underserved areas. They are: Kentucky, Missouri and Utah.

Changes to This Plan

This Plan's High Option Self Only premiums have increased by 16.8%; High Option Self and Family premiums have increased by 17%.

This Plan's Standard Option Self Only premiums have increased by 10%; Standard Option Self and Family premiums have increased by 10%.

If you live in an area that has medical PPO providers available but you do not use a provider in the PPO network, your out-of-pocket expenses will increase. The Plan will reimburse your claim at 70% of the rate it would have paid had you used a medical PPO provider. For example, if your Non-PPO provider charged $100 for a visit and the Plan's PPO rate for the visit is $80, the Plan will pay 70% of $80, or $56. You are responsible for the difference between $100 and $56, or $44. This applies only when you have access to a medical PPO provider but do not use one. See definition of reasonable and customary (page 43) for further details.

The Plan has added a $150 per person calendar year deductible for High Option, up to a family limit of $450. The calendar year deductible for Standard Option has increased to $200 per person, up to a family limit of $600. This will eliminate the current $100 durable medical equipment deductible, the $250 and $300 surgical facilities deductible, the $100 deductible on certain Standard Option outpatient charges and the $50 "copayment" on surgery and anesthesia. (The prescription drug deductibles still apply.) These deductibles do not apply to doctor's outpatient medical visits.

The Plan will reduce the coinsurance rate for professional services under High Option PPO benefits to 90% (from 95% or in some cases 100%) for inpatient surgical, medical and maternity, and outpatient hospital, surgical, medical and maternity benefits.

Section 2. How We Change for 2000 *continued*

Changes to This Plan
(continued)

The Plan will change its reimbursement of emergency treatment (both illness and accident) to pay PPO benefits under High and Standard Options at 90% of covered charges, subject to the applicable calendar year deductible. For Non-PPO benefits under High and Standard Options, the Plan pays 70% of reasonable and customary charges, subject to the applicable calendar year deductible.

The Plan will add a network of preferred dentists to the High Option (only) Dental benefits. These dentists will provide services at discounted rates.

The Plan will increase its reimbursement for outpatient care for mental conditions and substance abuse for Both Options from 50% to 70% of reasonable and customary charges, up to the 20 outpatient annual visit limit, subject to the applicable calendar year deductible.

The Plan will implement drug management programs that will require preauthorization and/or limit dispensing quantities of some categories of drugs. These categories include growth hormone, acne medications, antiemetics, migraine medications and drugs used to treat attention deficit disorder and narcolepsy.

The Plan will change the mail order prescription drug copayments to the following three tier level: Under High Option, you will pay a $10 copay per generic, a $30 copay per preferred brand name drug and a $45 copay per non-preferred brand name. Under Standard Option, you will pay a $10 copay per generic, a $40 copay per preferred brand name drug and a $55 copay per non-preferred brand name. Current prescription drug deductibles remain.

The Plan will change the retail prescription drug benefit to require you to pay any amount in excess of the cost of a generic drug when a generic drug is available and the physician does not specify that the prescription must be dispensed as written.

The Plan will change the retail prescription drug benefit whereby members who use a PCS network pharmacy, but do not present their card at the pharmacy, will be reimbursed (when a paper claim is filed) at Mail Handlers' cost had the member obtained the PCS discount.

The Plan will change the retail prescription drug benefit for prescriptions purchased at a non-PCS participating pharmacy in the United States. The Plan's benefit for such purchases will be limited to an amount that would have been paid if purchased at a PCS participating pharmacy. You may incur greater out-of-pocket expenses for such purchases.

The Plan will increase the catastrophic protection limit from $3,000 to $4,000 for non-PPO services under High Option. For PPO services under High Option, the catastrophic limit will increase from $2,000 to $2,500. For both PPO and non-PPO services under Standard Option, the catastrophic limit will increase from $3,000 to $4,000.

The Plan will change its coverage for Chelation Therapy to an inpatient (only) acute care benefit.

The Plan will eliminate the current Nurse Advice/Triage telephone service.

The Plan will change its reimbursement for ambulance and nursing care services under High and Standard Options to pay 70% of the reasonable and customary charges, subject to the applicable calendar year deductible.

The Plan has added coverage for allogenic (donor) bone marrow transplants to treat chronic myelogenous leukemia, and for autologous bone marrow transplants to treat chronic lymphocytic leukemia.

The Plan has added PPO vendors for durable medical equipment. The Plan will change its reimbursement for these services to pay 90% of the covered charges for PPO vendors, and 70% of the reasonable and customary charges for non-PPO vendors, subject to the applicable calendar year deductible. The Plan will also limit benefits for the rental of durable medical equipment to an amount equal to what would be paid for the purchase of the equipment.

The Plan will change its reimbursement for orthopedic and prosthetic appliances under High and Standard Options to pay 90% of the reasonable and customary charges, subject to the applicable calendar year deductible.

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 inpatient admissions and the flexible benefits option. Some include managed care options, such as PPOs, to help contain costs.

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 the Plan 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 pages 40–41 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Plan has the authority to determine the most effective way to provide services. The Plan 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. The Plan may decide to resume regular contract benefits at its 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 the Plan's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

PPO

This Plan offers most of its members the opportunity to reduce out-of-pocket expenses by choosing providers who participate in the Plan's preferred provider organization (PPO). Consider the PPO cost savings when you review Plan benefits and check with the Plan to see whether PPO providers are available in your area.

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 and other measures are described in more detail below.

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. Each family member must satisfy all applicable deductibles. Deductibles do not calculate to the catastrophic protection benefit.

Calendar year deductible

Calendar year deductible is the amount of expense an individual must incur for certain covered services and supplies each calendar year before the Plan pays benefits for those expenses. Only those expenses covered under each provision may be applied toward that deductible. The deductible is $150 per person per year for the High Option and $200 per person per year for the Standard Option. For Family coverage, you and your family can also meet this deductible by accumulating up to three times this deductible per family, $450 on the High Option, and $600 on the Standard Option.

Hospital admission

The hospital deductible is $250 per medical, maternity, and mental conditions/substance abuse admission under High Option and $300 per admission under Standard Option. If confinement is in a PPO hospital, under High Option the deductible is waived; under Standard Option the deductible is reduced to $150.

How much do I pay for services? *(continued)*

Deductibles *(continued)*

Prescription drugs

There is a $250 prescription drug deductible per person, per calendar year under High Option and a $600 prescription drug deductible per person, per calendar year under Standard Option.

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.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after meeting the applicable deductible. The Plan will base this percentage on the negotiated rates for PPO providers and on the lesser of the billed charge or the reasonable and customary charge for non-PPO providers. You are required to pay the following coinsurance on benefits under this Plan: If you use a PPO provider, you pay 10% of the negotiated rates for chemotherapy, radiation therapy, hemodialysis, machine diagnostic tests and procedures, doctors' inpatient visits, surgery, anesthesia, emergency room visits, durable medical equipment, and obstetrical care. If you use non-PPO providers, you pay 30% of negotiated or reasonable and customary charges for inpatient mental conditions/substance abuse, outpatient surgical facilities, chemotherapy, radiation therapy, hemodialysis, machine diagnostic tests and procedures, doctors' visits (inpatient and outpatient), surgery, anesthesia, obstetrical care, emergency room visits, ambulance, nursing visits, and durable medical equipment. You pay 25% under High Option and 30% under Standard Option of actual charges for prescription drugs purchased at a PCS network pharmacy. You pay 50% of actual charges for prescription drugs purchased at a non-PCS network pharmacy.

After you meet any deductible, the coinsurance is the minimum amount you will have to pay. When the Plan pays 70% of reasonable and customary charges for a covered service, you are responsible for the 30% coinsurance. In addition, you are responsible for any excess charge over the Plan's reasonable and customary allowance under most circumstances. 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 70% of the allowance, which is $66.50. You must pay the 30% coinsurance, which is $28.50, plus the difference between the actual charge and the reasonable and customary allowance, which is $5, for a total member payment of $33.50.

Copayments

A copayment is the stated amount you must pay for certain covered services before the Plan makes its payment. For instance, when you visit a PPO provider for a covered out of hospital visit, after you pay the $15 copayment, the Plan will pay the remainder of the covered charge for the visit.

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 charges. 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 30% coinsurance, the actual charge is $70. The Plan will pay $49 (70% of the actual charge of $70).

Annual maximums

There is a $1,500 cumulative annual maximum for outpatient therapy services (physical therapy, speech therapy, occupational therapy, chiropractic, and acupuncture services).

Lifetime maximums

There is a $5,000 per person lifetime maximum under both options for inpatient and outpatient hospice care, and a $100 per person lifetime maximum under the smoking cessation benefit. If a person changes options in this Plan, all benefits paid under the former option and charged against a lifetime maximum will count against the corresponding lifetime maximum under the new option.

How much do I pay for services? *(continued)*

Do I have to submit claims?

You usually do not have to submit claims to us if you use medical preferred providers. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control, such as administrative delay of government or legal incapacity, 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

Hospice

A facility that:

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

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

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

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

(5) provides an ongoing quality assurance program.

Hospital

An institution that is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or any other institution that is operated pursuant to law, under the supervision of a staff of doctors (M.D. or D.O.) and with 24-hour-a-day nursing services, and that is primarily engaged in providing:

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

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

(c) a licensed birthing center.

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

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

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

(c) is operated as a school; or

(d) is operated as a residential treatment facility regardless of its State licensure or accreditation status.

Covered Providers

For purposes of this Plan, covered providers include: 1) a licensed doctor of medicine (M.D.), or a licensed doctor of osteopathy (D.O.), hereafter referred to as a doctor; and 2) for certain specified services covered by this Plan, a licensed doctor of podiatry (D.P.M.), a licensed dentist, a chiropractor, a licensed clinical physical therapist, a licensed occupational therapist, or a licensed speech therapist. Other covered providers include qualified clinical psychologist; clinical social worker; optometrist; audiologist; acupuncturist; physician's assistant; nurse midwife; nurse practitioner/clinical specialist; and nursing school-administered clinic. Covered providers must be appropriately licensed or certified as determined by the Plan. 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.

Who provides my health care? *(continued)*

MultiPlan Participating Providers

This Plan has a contract with MultiPlan. MultiPlan has entered into contracts with hospitals and doctors who have agreed to discount their charges. The Plan will consider these providers as participating providers and will process their covered inpatient hospital claims at 100% of the negotiated amount, subject to the applicable per-admission deductible, and at 70% of the negotiated amount for covered outpatient services, subject to the applicable calendar year deductible. Call the Plan for the names of MultiPlan providers near you.

PPO arrangements

Benefits under this Plan are available from facilities, such as hospitals, and from providers, doctors, and other health care personnel, who provide covered services. 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 services to Plan members at a lower cost than you'd usually pay for a non-PPO provider. Although PPOs 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 Plan's responsibility. PPO providers are independent contractors and final decisions about health care are the sole responsibility of the doctor and patient. However, benefit decisions made by the Plan are dependent upon all the terms of this brochure. Continued participation of any specific provider cannot be guaranteed.

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 you receive non-covered services from a PPO provider, the PPO discount will not apply and these services will be excluded from coverage.)

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

Non-PPO facilities and providers do not have special agreements with the Plan. The Plan will consider the reasonable and customary charges (see definition) for covered services, and you're responsible for any balance.

This Plan's medical PPO

If confinement in a PPO hospital is chosen, and precertification of hospital services is obtained, under High Option the inpatient hospital deductible will be waived; under Standard Option the inpatient hospital deductible will be $150. If PPO doctors are chosen, the Plan will pay 100% of the covered charges for outpatient physicians visits after a $15 copayment except for allergen immunotherapy (i.e., allergy shots) where the Plan pays 100% after a $5 copayment. If a PPO provider is chosen for inpatient physician visits, outpatient X-ray and machine tests, laboratory services, emergency treatment of illness or injury, maternity, surgical and anesthesia services, and physical therapy, chiropractor and acupuncture visits, the Plan will pay 90% of the covered charges. Drugs purchased at a pharmacy are not subject to PPO benefits. Drugs supplied or administered by a PPO provider are eligible for PPO benefits.

PPO hospitals, doctors, and laboratories will submit Mail Handlers Benefit Plan claims on your behalf, and all PPO benefits will be paid directly to the participating hospital, doctor, or laboratory. Using a PPO hospital doesn't guarantee that all care received will be rendered by a PPO doctor or provider. This includes, but is not limited to, emergency room physicians, pathologists, radiologists, and anesthesiologists.

PPO information, including whether or not your city or town is part of a PPO network, can be obtained by calling a Customer Relations Associate at the Regional Service Center at 1-800-410-7778, or by visiting the Plan's website www.mhbp.com. Participating hospitals, doctors, and laboratories are also listed in directories that the Plan sends to its members. When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

This Plan's dental PPO

The Plan offers access to a network of dentists who have agreed to provide services at a discounted rate. To learn of a preferred dentist in your area, call 1-888-788-5702 or visit the Plan's website www.mhbp.com. For information about the Plan's benefits, call customer relations at 1-800-410-7778 or visit the Plan's website.

If PPO providers are available in your area and you do not use them

Effective January 1, 2000, it is even more important to use the Plan's PPO network providers. In past years if you did not use PPO providers even though they were available in your area, your expenses were paid as regular Non-PPO benefits with the Plan's allowance determined by the reasonable and customary charge (see definition on page 43). This has changed. If PPO providers are available in your area and you do not use them, your out-of-pocket expenses will increase. The Plan will base its allowance on a fee schedule that represents an average of the PPO fee schedules for a particular service in a particular geographic area (see definition of reasonable and customary, page 43, for further details). You can call the Plan at 1-800-410-7778 for information about the availability of PPO providers in your area or to determine the amount of your out-of-pocket expenses.

Those members who do not have adequate access (in terms of distance from where you live to a network provider) or those receiving emergency care will not be affected. The Plan's allowance in these cases will be based on the reasonable and customary allowance.

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

First, call the Plan's Customer Relations Department at 1-800-410-7778. If you are new to the FEHB Program, we will reimburse your 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 specialty 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 continue to see your OB/GYN until the end of your postpartum care.

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

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.

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

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

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

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

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

Section 4. What to Do if We Deny Your Claim or Request for Preauthorization

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 the provider 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 any other documentation that supports your claim.

If we deny your request for preauthorization or won't pay your claim (or a part thereof), you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show 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;
3. Approve your request for coverage or preauthorization; or
4. Ask for more information.

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

When may I ask OPM to review a denial?

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

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

Call us at 1-800-410-7778 and we will expedite our review.

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

If we expedite your review due to a serious medical condition and deny your 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 or refusal. You may also ask OPM to review your claim if:

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

What do I send to OPM?

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

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

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

Who can make the request?

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

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

Where should I mail my disputed claim to OPM?

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

What if OPM upholds the Plan's denial?

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

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

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits (See 5 U.S.C. §8901(m)(1) and 5 CFR 890). The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

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

Section 5. Benefits

All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable when determined by the Plan to be medically necessary.

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. If your stay is greater than 23 hours, services will be considered inpatient, subject to precertification guidelines. See pages 40–41 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. For information on when Medicare is primary, see pages 35–37.

Room and board

Benefits are available for semiprivate room or ward, intensive care or progressive care (step down), or a private room when isolation is required by law or when the Plan determines isolation is medically necessary to prevent contagion. (If you are confined in a private room for any other reason, the Plan will pay the semiprivate room rate most frequently charged by that hospital.)

PPO benefit	**High Option:** The Plan pays **100%** with no deductible.	**Standard Option:** After the $150 per-admission deductible, the Plan pays **100%.**
Non-PPO benefit	**High Option:** After the $250 per-admission deductible, the Plan pays **100%**.	**Standard Option:** After the $300 per-admission deductible, the Plan pays **100%**.

Other charges

Benefits are paid in full under both options for charges for all covered hospital services and supplies billed for by the hospital during the hospital confinement, including:

- General nursing care
- Drugs and medicines furnished by the hospital
- Use of operating room, recovery, or other treatment rooms
- Dressings
- X-rays
- Laboratory and pathology services
- Blood and blood plasma
- Autologous blood donations
- Machine diagnostic tests
- Meals and special diets

Inpatient Hospital Benefits *continued*

Limited benefits

Organ/tissue transplants

The maximum benefit for any organ/tissue transplant, as described on page 16, is $300,000 per occurrence. Benefits issued for charges related to complications arising during the transplant confinement (same admission) are subject to the $300,000 maximum. Included in the $300,000 maximum are hospital, surgical, and other medical expenses. The cost of related outpatient prescription drugs is not subject to this limit. Chemotherapy when supported by a bone marrow transplant or autologous stem cell support is covered only for specific diagnoses listed on page 16.

Hospitalization for dental work

The Plan pays Inpatient Hospital Benefits as shown above in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient.

Related benefits

Pre-surgical testing

See Other Medical Benefits, page 23, for benefits for diagnostic tests and procedures prior to an admission for surgery.

Professional charges

See page 21 for inhospital doctors' visits.

What is not covered

- A hospital admission, or portion thereof, that is not medically necessary (see definition), including an admission for medical services that did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered
- Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day
- Personal comfort items such as radio, television, telephone, guest beds, admission kits, or other comfort items
- Charges by institutions that do not meet the definition of a hospital
- Inpatient private-duty nursing
- Custodial care (as defined on page 42), even when provided by a hospital

The non-PPO benefits are the regular benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Surgical Benefits

What is covered (inpatient or outpatient)

The Plan pays for covered charges billed by a primary surgeon as follows:

PPO benefit	**High Option:** The Plan pays 90% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges after the $200 per person calendar year deductible has been met.
Non-PPO benefit	**High Option:** The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Surgical Benefits *continued*

Multiple surgical procedures

For multiple surgical procedures performed by the same surgeon, through the same incision, and during the same operative session:

PPO benefit	**High Option:** The Plan pays 90% of the covered charges for the primary procedure and 90% of half of the covered charges for the secondary procedure, after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges for the primary procedure and 90% of half of the covered charges for the secondary procedure, after the $200 per person calendar year deductible has been met.
Non-PPO benefit	**High Option:** The Plan pays 70% of the reasonable and customary charges for the primary procedure and 70% of half of the reasonable and customary charges for the secondary procedure, after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges for the primary procedure and 70% of half of the reasonable and customary charges for the secondary procedure, after the $200 per person calendar year deductible has been met.

Co-Surgeons

For surgical procedures performed by two surgeons, the Plan pays each surgeon 50% of what it would pay a single surgeon for the same surgical procedure(s).

Incidental procedures

An incidental procedure (e.g., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) can be part of the primary surgery or unrelated to the objective of the operative session. If a surgical procedure is deemed by the Plan to be incidental to the total surgery, benefits will not be provided for the incidental portion.

Assistant surgeon

When the services of an assistant surgeon are required by the primary surgeon and considered by the Plan to be medically necessary:

PPO benefit	**High Option:** The Plan pays 20% of the covered charges for surgery after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 20% of the covered charges for surgery after the $200 per person calendar year deductible has been met.
Non-PPO benefit	**High Option:** The Plan pays 20% of the reasonable and customary charges for surgery after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 20% of the reasonable and customary charges for surgery after the $200 per person calendar year deductible has been met.

Anesthesia

PPO benefit	**High Option:** The Plan pays 90% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges after the $200 per person calendar year deductible has been met.
Non-PPO benefit	**High Option:** The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Surgical Benefits *continued*

Organ/tissue transplants and donor expenses

Benefits will be provided the same as for any other illness or injury for covered expenses incurred for surgical transplant of a body organ/tissue (as defined below). Related donor medical and hospital expenses are covered when the recipient is covered by the Plan.

Surgical transplant of body organ/tissue means transfer of a body organ(s)/tissue(s) from the donor to the recipient (allogenic) or a bone marrow graft in which the donor and recipient are the same person (autologous). For purposes of this Plan, body organ/tissue includes only the organs and tissues listed below as "What is covered."

Donor means a person who undergoes a surgical operation for the purpose of donating a body organ(s)/tissue(s) for transplant surgery. Coverage for donor screening tests for organ/tissue transplants is limited to those performed on the actual donor.

What is covered

Benefits will be provided for the following transplants subject to the limitations shown:

- Cornea, heart, kidney, liver, pancreas, heart/lung, single lung, and double lung transplants
- Bone marrow and stem cell support as follows:

  Allogenic (donor) bone marrow transplants: chronic myelogenous leukemia, acute leukemia, aplastic anemia, severe combined immuno-deficiency disease, Wiscott-Aldrich syndrome, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphomas, and myelodysplastic syndrome (in advanced form).

  Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for chronic or acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphomas; resistant or recurrent neuroblastoma; testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer.
- Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.

The maximum benefit for any organ/tissue transplant(s) is $300,000 per occurrence. Included in the $300,000 maximum are hospital, surgical, and medical expenses of the recipient but not the covered expenses of the donor. Benefits issued for charges related to complications arising during the transplant confinement (same admission) are subject to the $300,000 maximum. The cost of outpatient prescription drugs related to the transplant is not subject to the $300,000 limit. Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support, is covered only for the specific diagnoses listed above.

What is not covered

- Services or supplies for or related to surgical transplant procedures for artificial or human organ/tissue transplants not specifically listed as covered. Related services or supplies include administration of chemotherapy when supported by transplant procedures.
- Donor screening tests for organ/tissue transplants, except those performed on the actual donor.

Oral and maxillofacial surgery

The following procedures are covered:

- Reduction of fractures of the jaws or facial bones
- Removal of impacted teeth that are not completely erupted (bony, partial bony, and soft tissue impactions)
- Surgical correction of cleft lip, cleft palate, or protruding mandible
- Removal of stones from salivary ducts
- Excision of tori, leukoplakia, or malignancies
- Temporomandibular joint dysfunction surgery
- Other surgical procedures that do not involve the teeth or their supporting structures.

Note: Procedures that involve the teeth or their supporting structures, such as periodontal membrane, gingiva, and alveolar bone, are not considered covered oral surgery. These procedures may be considered as covered dental procedures under the High Option dental benefits. There is no coverage for dental implants or related procedures (see pages 28–30).

Surgical Benefits *continued*

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.

Related benefits

Pre-surgical testing

Outpatient diagnostic tests and procedures performed prior to surgery are covered under Outpatient diagnostic laboratory, X-ray, and machine diagnostic tests benefits as described under Other Medical Benefits, page 23.

Eyeglasses/lenses

Eyeglasses or contact lenses to correct an impairment directly caused by an accidental injury or covered intraocular surgery are covered as Additional Benefits on page 25.

Casting

Services and supplies related to casting are considered under the surgical benefit.

Limited benefit

Cosmetic surgery

Cosmetic surgery (see definition) and all services related thereto are limited to surgery necessary to correct a congenital anomaly (see definition), or to promptly repair an injury caused by an accident.

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

- Removal of corns or calluses or trimming of nails, including debridement, regardless of diagnosis
- Eye surgery such as radial keratotomy or laser procedures, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness), or astigmatism (blurring)
- Reversal of surgically induced sterilization
- Services of a stand-by surgeon

The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

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 cesarean delivery. Inpatient stays will be extended if medically necessary.

For Whom

Benefits are payable under Self Only enrollments, and for family members under Self and Family enrollments.

Inpatient hospital

Precertification

Precertification is not required for maternity admissions for routine deliveries. However, if your medical condition requires that you stay more than 48 hours after a regular delivery or 96 hours after a cesarean section, you, your physician, or the hospital must contact the Plan for certification of the additional days. If the certification for additional days is not obtained and a retrospective medical review determines the additional days were not medically necessary, the Plan will not pay for charges incurred on those noncertified days. If certification is not obtained but the benefits are otherwise payable, benefits for the admission will be reduced by $500. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 40–41 for details.

Maternity Benefits *continued*

Newborn precertification

Any additional hospital days for a newborn who requires care beyond the mother's stay must be precertified under the guidelines for emergency admissions.

Room and board

For semiprivate room and board and other covered hospital services and supplies:

PPO benefit

High Option: The Plan pays 100% with no deductible.	**Standard Option:** The Plan pays 100% after the $150 per-admission deductible.

Non-PPO benefit

High Option: The Plan pays 100% after the $250 per-admission deductible.	**Standard Option:** The Plan pays 100% after the $300 per-admission deductible.

Other charges

Bassinet and nursery charges for days when both mother and child are confined are considered maternity expenses of the mother and not expenses of the child. Charges incurred by the child as a result of illness, including but not limited to pediatric intensive care charges and neonatal services, are considered expenses of the child, not the mother, and are subject to a separate inpatient deductible. These charges are covered only if the child is covered under a Self and Family enrollment, and the deductible and coinsurance may be waived or reduced the same as the mother's when a PPO is used.

Birthing centers

Care for delivery in a birthing center is eligible for inpatient benefits.

Obstetrical care

For obstetrical or midwife charges, including pre- and post-natal visits:

PPO benefit

High Option: The Plan pays 90% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges after the $200 per person calendar year deductible has been met.

Non-PPO benefit

High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Maternity benefits will be paid at the termination of pregnancy.

Anesthesia

PPO benefit

High Option: The Plan pays 90% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges after the $200 per person calendar year deductible has been met.

Non-PPO benefit

High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Maternity Benefits *continued*

Newborn exam

For doctor's initial medical examination of a newborn child:

PPO benefit

High Option	Standard Option
High Option: The Plan pays 90% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges after the $200 per person calendar year deductible has been met.

Non-PPO benefit

High Option	Standard Option
High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Related benefits

Outpatient X-ray and laboratory tests

Outpatient X-ray procedures and laboratory tests related to maternity care are covered under Other Medical Benefits (see page 23).

Diagnosis and treatment of infertility

Testing related to the diagnosis of infertility is covered under Other Medical Benefits. Prescription drugs for the treatment of infertility are covered as Prescription Drug Benefits.

Voluntary sterilization

Benefits for voluntary sterilization are paid under Surgical Benefits (see pages 14–17).

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
- A reversal of surgically induced sterilization
- Contraceptive drugs, except as covered under Prescription Drug Benefits (see pages 26–28)
- Charges for care received after enrollment in this Plan ends
- Stand-by doctors
- Home uterine monitoring devices

The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Mental Conditions/Substance Abuse Benefits

What is covered

Mental Conditions/Substance Abuse Benefits are paid instead of other benefits under this Plan for all expenses for treatment of mental conditions and substance abuse as shown on pages 20–21.

Inpatient care

Inpatient confinements for the diagnosis and treatment of mental conditions and substance abuse in a hospital are covered as follows:

Precertification

The medical necessity of your admission to a hospital 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 pages 40–41 for details.

PPO benefit

High Option: The Plan pays 70% of the covered inpatient charges up to 45 days per calendar year.

Standard Option: The Plan pays 70% of the covered inpatient charges after the $150 per admission deductible up to 45 days per calendar year.

Non-PPO benefit

High Option: The Plan pays 70% of the covered inpatient charges up to 45 days per calendar year after the $250 per admission deductible.

Standard Option: The Plan pays 70% of the covered inpatient charges up to 45 days per calendar year after the $300 per admission deductible.

Related Benefit

Doctors' inhospital visits

High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.

Standard Option: The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Outpatient care

The Plan covers outpatient visits for diagnosis and treatment of mental conditions and substance abuse. One day in a partial hospitalization/day treatment program is considered as one outpatient visit.

High Option: The Plan pays 70% of the reasonable and customary charges, limited to 20 outpatient visits per year, subject to the $150 per person calendar year deductible.

Standard Option: The Plan pays 70% of the reasonable and customary charges, limited to 20 outpatient visits per year, subject to the $200 per person calendar year deductible.

Related Benefit

Electroshock therapy, diagnostic tests, and laboratory procedures

High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.

Standard Option: The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

What is not covered

- A hospital admission, or portion thereof, when, in the Plan's judgement, the confinement is not medically necessary, i.e., the care provided did not require an acute hospital (inpatient) setting, but could have been provided in some other setting without adversely affecting the patient's condition or the quality of the care rendered. For example, substance abuse rehabilitation admissions which do not require medical management for a safe detoxification are considered to be subacute care, and the room and board charge for the admission or a portion of the stay will not be covered.

Mental Conditions/Substance Abuse Benefits *continued*

What is not covered *(continued)*

- Services rendered or billed by institutions that do not meet the definition of a hospital, including licensed residential treatment centers or facilities that are accredited by JCAHO as freestanding mental health care organizations
- Services by pastoral counselors, family/marital counselors, alcohol/substance abuse counselors, and other non-covered providers
- Counseling or therapy for marital, family, educational, behavioral, or sexual problems

The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Other Medical Benefits

What is covered

Physician services

The Plan covers doctor's hospital, home, and office visits and consultations at the benefits levels shown below except for those related to normal post-operative care which are covered under Surgical Benefits. This benefit applies to visits related to chemotherapy, X-ray, or radium treatment for cancer, and dialysis treatment. Also payable under this benefit are venipuncture-blood drawing and adult immunizations. In addition, professional services related to cortisone injection therapy are considered under this benefit. Covered prescription drugs and supplies administered or dispensed during a visit or consultation are also payable.

Hospital visits

PPO benefit	**High Option:** The Plan pays 90% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges after the $200 per person calendar year deductible has been met.
Non-PPO benefit	**High Option:** The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Out-of-hospital visits (medical visits when you are not hospitalized)

PPO benefit	**Both Options:** The Plan pays 100% of the covered charges after a $15 copayment per visit.
Non-PPO benefit	**Both Options:** The Plan pays 70% of the reasonable and customary charges.

For additional services provided during an office visit, see outpatient diagnostic X-ray, laboratory and machine tests on page 23.

Other outpatient visits

For outpatient physical, speech, occupational therapy, chiropractic services, and acupuncture:

PPO benefit	**High Option:** The Plan pays 90% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges after the $200 per person calendar year deductible has been met.
Non-PPO benefit	**High Option:** The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Other Medical Benefits *continued*

Other outpatient visits *(continued)*

There is one $1,500 annual maximum per person (for both PPO and non-PPO benefits) related to any combination of outpatient therapy, chiropractic, and acupuncture services. The Plan will not pay in excess of the $1,500 annual maximum for these services, even from the Catastrophic Protection Benefit.

For additional services provided during a visit, see outpatient diagnostic X-ray, laboratory and machine tests on page 23.

Allergy injections

For professional services related to the administration of allergy serum:

PPO benefit

Both Options: The Plan pays 100% of the covered charges after a $5 copayment.

Non-PPO benefit

Both Options: The Plan pays 70% of the reasonable and customary charges.

Hospital outpatient care

Surgical facility services

Under both options when a member undergoes a covered outpatient surgical procedure, the Plan pays the surgical facility charge for related services and supplies rendered on that day and billed by the outpatient department of a hospital or surgi-center as shown below. If the stay is greater than 23 hours, services will be considered as inpatient care, subject to precertification requirements (see pages 40–41). Note: For services rendered and billed by the surgeon and/or anesthetist, see Surgical Benefits on pages 14–17.

PPO benefit

High Option	Standard Option
High Option: The Plan pays 100% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 100% of the covered charges after the $200 per person calendar year deductible has been met.

Non-PPO benefit

High Option	Standard Option
High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 7% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Other outpatient care

Under both options, the Plan pays outpatient cancer treatment (chemotherapy, X-rays, or radium therapy), dialysis services (hemodialysis or peritoneal dialysis), and hyperbaric oxygen therapy ordered by a doctor and provided by a hospital (as an outpatient) or clinic as follows:

PPO benefit

High Option	Standard Option
High Option: The Plan pays 90% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges after the $200 per person calendar year deductible has been met.

Non-PPO benefit

High Option	Standard Option
High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Note: Retail pharmacy charges for chemotherapy and prescriptions to treat the side effects of chemotherapy are covered under Prescription Drug Benefits, as described on pages 26–28.

Other Medical Benefits *continued*

Emergency treatment

For accidental injury — The Plan pays charges as described below for covered services and supplies furnished to an outpatient in connection with emergency treatment or surgery performed within 72 hours of an accident. (Related follow-up care received after 72 hours is payable under the physician services benefit.) Emergency treatment that results in an admission is payable under the inpatient hospital/physician services benefits.

For illness — The Plan pays charges as described below for covered services and supplies furnished to an outpatient in connection with emergency treatment of illness or mental conditions/substance abuse performed within 72 hours of the occurrence. Services must be rendered in a hospital emergency room or urgent care center. Charges for either initial or follow-up treatment rendered in a doctor's office will be paid under the physician services benefit.

PPO benefit

High Option	Standard Option
High Option: The Plan pays 90% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges after the $200 per person calendar year deductible has been met.

Non-PPO benefit

High Option	Standard Option
High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Outpatient diagnostic X-ray, laboratory and machine tests

For covered diagnostic X-ray, laboratory and machine diagnostic tests related to a covered illness or injury:

PPO benefit

High Option	Standard Option
High Option: The Plan pays 90% of the covered charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 90% of the covered charges after the $200 per person calendar year deductible has been met.

Non-PPO benefit

High Option	Standard Option
High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.	**Standard Option:** The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Performance Lab

The Plan offers a laboratory services benefit that is strictly voluntary. In order to take advantage of this benefit, you must present your Mail Handlers Benefit Plan identification card and request that your physician send the lab order and specimen to LabCorp. As long as the testing is performed by LabCorp, you will not have to file any claims and will not be subject to a deductible and/or copayment or coinsurance. If you have this Plan as your primary insurance, you can take advantage of this non-emergency outpatient laboratory testing service at no cost to you. To learn of a location nnear you, call 1-888-522-2677, or visit the Plan's website www.mhbp.com.

Both Options: The Plan pays 100% of the covered charges.

Other Medical Benefits *continued*

Routine services

The following routine (screening) services, including associated office visits, are covered the same as any other lab or diagnostic service (see Outpatient diagnostic X-ray, laboratory and machine tests described above):

Breast cancer screening

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

- From ages 35 through 39, one mammogram screening during this five-year period;
- From ages 40 through 64, one mammogram screening every calendar year;
- At age 65 or over, 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 (stool) test for members age 40 and older.

Coverage for screening sigmoidoscopy once every two (2) years for members age 50 and older.

Prostate cancer screening

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

Limited benefits

Childhood immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered for eligible members under age 22.

PPO benefit

Both Options: The Plan pays 100% of the covered charges.

Non-PPO benefit

Both Options: The Plan pays 100% of the reasonable and customary charges.

Smoking cessation benefit

The Plan will pay up to $100 for enrollment in one smoking cessation program per member, per lifetime. All claims for smoking cessation benefits will be paid directly to you. Prescription drugs for smoking cessation are paid under Prescription Drug Benefits, and their cost does not count toward the $100 limit; see pages 26–28.

Well-child care

Well-child office visits to a doctor (those not related to an illness or injury) for covered dependents up to age eighteen (18) are paid as follows:

PPO benefit

Both Options: After a $15 copayment per visit, the Plan pays up to $100 per year, per child.

Non-PPO benefit

Both Options: The Plan pays up to $75 per year, per child.

What is not covered

- Routine physical examinations, except for well-child care visits
- Routine X-ray and laboratory tests except for routine mammograms, screening sigmoidoscopy, an annual routine Pap smear, an annual PSA test, and an annual stool test for occult blood
- Chelation therapy, except if the covered services and supplies are provided during a precertified inpatient admission
- Charges for thermography and related visits
- Chemotherapy supported by a bone marrow transplant, or with stem cell support, for any diagnosis not listed as covered on page 16
- Laboratory handling charges
- Office visits and related services in connection with orthoptics
- Routine foot care

The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Additional Benefits

Ambulance benefit

The Plan pays for professional local ambulance service to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is not available or suitable at the first hospital, and from the hospital to another medical facility if required for the patient to receive necessary treatment. Air ambulance is covered to the nearest hospital where treatment is available and is only covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation.

High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.

Standard Option: The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Durable medical equipment and orthopedic and prosthetic appliances

The Plan pays for the outpatient rental (or purchase, at the Plan's option, if less expensive), of durable medical equipment and for the purchase of orthopedic and prosthetic appliances (see definitions) when recommended by an M.D. or D.O.

The Plan will limit its benefit for the rental of durable medical equipment to an amount no greater than what it would have paid if the equipment had been purchased. For instance, if the equipment could be purchased for $150, but the rental cost is $50 per month, the Plan will not pay for more than 3 months rental.

The Plan will also pay for necessary repairs or adjustments to purchased medical equipment and supplies used solely in connection with the durable medical equipment. This provision also includes coverage for: wheelchairs, hospital beds, oxygen equipment, and other items determined by the Plan to be durable medical equipment.

Call the Plan at 1-800-410-7778 to get information about durable medical equipment PPO vendors.

PPO Benefit

High Option: The Plan pays 90% of the covered rental or purchase price for each item after the $150 per person calendar year deductible has been met.

Standard Option: The Plan pays 90% of the covered rental or purchase price for each item after the $200 per person calendar year deductible has been met.

Non-PPO Benefit

High Option: The Plan pays 70% of the reasonable and customary rental or purchase price for each item after the $150 per person calendar year deductible has been met.

Standard Option: The Plan pays 70% of the reasonable and customary rental or purchase price for each item after the $200 per person calendar year deductible has been met.

Orthopedic and prosthetic appliances

For orthopedic and prosthetic appliances (see definitions) when recommended by an M.D. or D.O.:

High Option: The Plan pays 90% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.

Standard Option: The Plan pays 90% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Eyeglasses/lenses

The Plan pays up to $50 for one set of eyeglasses or $100 for contact lenses (including examination) after the $150 per person calendar year deductible for High Option or the $200 per person calendar year deductible for Standard Option if required to correct an impairment directly caused by an accidental ocular injury or covered intraocular surgery. This benefit is available up to one year following the accident or surgery, provided you are still enrolled in this Plan.

Additional Benefits *continued*

Hearing aid

The Plan pays up to $200 for one hearing aid per ear (including examination) after the $150 per person calendar year deductible for High Option or the $200 per person calendar year deductible for Standard Option if required to correct an impairment directly caused by an accident. This benefit is available up to 120 days following the accident, provided you are still enrolled in this Plan.

Hospice care program

The Plan pays actual charges up to a lifetime maximum of $5,000 per person, for any combination of inpatient and outpatient hospice care.

Nursing care services

The Plan pays for the outpatient services of a registered graduate nurse (R.N.) or a licensed practical nurse (L.P.N.), if recommended by an M.D. or D.O., up to an annual maximum of $700.

There is a $700 annual maximum per person related to nursing care services. The Plan will not pay in excess of the $700 annual maximum for these services, even from the Catastrophic Protection Benefit.

High Option: The Plan pays 70% of the reasonable and customary charges after the $150 per person calendar year deductible has been met.

Standard Option: The Plan pays 70% of the reasonable and customary charges after the $200 per person calendar year deductible has been met.

Rabies shots

The Plan pays in full for rabies shots and related services.

What is not covered

- Durable medical equipment replacements provided less than three years after the last one for which benefits were paid
- Charges for service contracts for purchased durable medical equipment
- Items that are not durable medical equipment (see definitions), such as wheelchair ramps, outpatient exercise equipment (including treadmills and exercise bicycles), air conditioners, air purifiers, humidifiers, ultraviolet lighting (except for the treatment of psoriasis), and motorized scooters (see definition), computer “story boards”, “light talkers”, enhanced vision system or other communication aids for communication impaired individuals; prone standers; computer switchboards; lifts, such as seat, chair, or van lifts; safety and hygienic equipment
- Podiatric (foot) orthotics/orthopedic appliances (devices that can be placed in or on the shoe) such as arch supports, metatarsal bars, metatarsal pads, heel pads, heel cups, or corrective (orthopedic) shoes unless attached to a brace
- Wigs
- Supportive devices such as elastic stockings, corsets, elastic bandages, or trusses
- Dental appliances used to treat sleep apnea
- Ambulance or other transportation services used for the purposes of receiving non-emergency outpatient care
- Routine eye and ear exams

Prescription Drug Benefits

What is covered

The following medications and supplies are covered when prescribed by a doctor and furnished by a pharmacy or mail order program (this Plan administers an open formulary):

- Drugs and medicines that by Federal law of the United States require a doctor's written prescription, including chemotherapy and drugs used to treat the side effects of chemotherapy
- Disposable needles and syringes, alcohol swabs, and ostomy supplies
- Insulin and related testing material
- Hormone-based contraceptives, including Norplant (Norplant insertions are covered under Surgical Benefits)
- Smoking deterrents

Note: The Plan requires preauthorization and may limit dispensing quantities for some categories of drugs. These categories include: growth hormone, acne medications, antiemetics (antinausea drugs), migraine medications, drugs used to treat Attention Deficit Disorder and narcolepsy.

Related benefits

Chemotherapy

See page 22 for benefits for chemotherapy rendered in an outpatient facility.

What is not covered

- Outpatient medical supplies that do not require a prescription except those listed above
- Vitamins and nutritional supplements, except those requiring a prescription by law
- Anorexiants/appetite suppressants or prescription drugs for weight loss
- Supplies for parenteral nutrition
- Drugs prescribed for sexual dysfunction or sexual inadequacies
- Prescription Drug Benefits as a secondary payor in cases when members have other prescription drug coverage
- Any amount in excess of the cost of a generic drug when a generic is available and the physician has not specified that the pharmacist dispense the brand name drug only
- Any amount in excess of a network pharmacy's best price when you use a PCS participating pharmacy but do not present your Mail Handlers Benefit Plan ID card

PCS participating pharmacy and drug claims from foreign pharmacies if you live outside the United States

Present your Mail Handlers Benefit Plan ID card to the pharmacy with your prescription and pay the applicable deductible or coinsurance. If you do not present your ID card, you will not receive the PCS best price for that prescription. The PCS participating pharmacy files your claim and is reimbursed by the Plan. Do not send a copy of the claim to the Plan. Call the Plan at 1-800-410-7778 to find out the names of PCS participating pharmacies in your area or visit the plan's website www.mhbp.com. Note: In most cases, refills cannot be obtained until 75% of the drug has been used

High Option: After the $250 deductible per person, the Plan pays 75% of the covered charge.	**Standard Option:** After the $600 deductible per person, the Plan pays 70% of the covered charge.

Non-PCS participating pharmacy (excluding drug claims from outside the United States)

Non-PCS participating pharmacies in the United States and home health agencies are paid as follows:

High Option: After the $250 deductible per person, the Plan pays 50% of the price a PCS participating pharmacy would have charged for the same prescription.	**Standard Option:** After the $600 deductible per person, the Plan pays 50% of the price a PCS participating pharmacy would have charged for the same prescription.

Prescription Drug Benefits *continued*

Non-PCS participating pharmacy (including drug claims from outside the United States purchased by United States residents) *(continued)*

To file a prescription drug claim (for prescriptions obtained from a non-PCS participating pharmacy), complete a prescription drug claim form, attach the original receipt/document supplied by the pharmacy, and send it to the address below. The original receipt/document from the pharmacy must contain the following information: pharmacy name; patient name; date filled (the date the prescription was purchased); prescription number; drug name and strength (the name of the drug prescribed and the dosage); amount dispensed (for example, the number of pills); prescribing doctor's name; and the total prescription charge (dollar amount paid for the prescription). The claim will not be processed unless the information is complete.

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

PCS Health Systems, Inc.
Attn: MHBP Claims
P.O. Box 52151
Phoenix, AZ 85072-2151

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

Mail Order Program for Maintenance Medications

The Plan and PCS Health Systems provide a mail service program for enrollees who take maintenance medications. Maintenance drugs are typically prescribed to treat long term medical conditions such as diabetes, high blood pressure, and asthma. To obtain additional information about the Mail Order Maintenance Drug Program and learn which drugs are on the preferred brand list, call the Plan at 1-800-410-7778.

High Option: After the $250 deductible per person, the Plan pays 100% after a $10 copayment per generic prescription, a $30 copayment per preferred brand prescription, and $45 per non-preferred brand prescription.	**Standard Option:** After the $600 deductible per person, the Plan pays 100% after a $10 copayment per generic prescription, a $40 copayment per preferred brand prescription, and $55 per non-preferred brand prescription.

Note: Not all maintenance prescription drugs are available through this program. In addition to the normal Plan exclusions, certain classes of drugs are not available under this program. The excluded classes of drugs are all injectables (except for Diabetic supplies and MS agents Betaseron, Avonex, and Copaxine), narcotics, hospital solutions and certain drugs such as antipsychotic agents and AIDS therapies and other drugs for which state or federal laws or medical judgement limit the dispensing amount to less than 90 days. However, these excluded drugs are covered under the retail prescription drug program.

High Option Dental Benefits

What is covered

High Option pays actual charges up to amounts specified in the schedule of dental allowances for covered dental procedures, up to a maximum benefit of $800 per person and $1,600 per family, per calendar year. There is no deductible for dental benefits. For covered dental procedures not shown, the Plan will pay, subject to the limits provided, amounts consistent with procedures which are shown.

The Plan is unable to return dental X-rays. Remind your dentist not to submit X-rays.

If, in the construction of a denture or any prosthetic dental appliance, the patient and the dentist decide on personalized restoration or to employ special techniques as opposed to standard procedures, the benefit provided will be limited to the amount payable for the standard procedures.

Charges for crowns, bridges, and dentures are usually incurred when they are ordered. The Plan pays benefits to cover such charges even if the enrollee later rejects the denture or appliance.

The following is a partial schedule of dental allowances.

High Option Dental Benefits *continued*

What is covered *(continued)*

ADA Code	Description of Service	Allowance
	Diagnostic	
00120	Periodic oral examination (limit one per year)	$ 7.50
00210	Intraoral — complete series (including bitewings) of X-rays (limit one per year)	22.00
00220	Intraoral-periapical — first film	3.25
00230	Intraoral — each additional film	2.25
00240	Intraoral — occlusal film	7.50
00270	Bitewing single film	2.75
00290	Posterior-anterior or lateral skull and facial bone survey	13.00
00330	Panoramic film	22.00
	Preventive (dollar amount shown is limit per calendar year)	
01110	Prophylaxis — adult (age 13 and over)	14.25
01120	Child to age 13	12.00
01203	Topical application of fluoride (prophylaxis not included), child	7.50
01204	Adult	7.50
01351	Sealant, per tooth	7.50
01510	Space maintainer — fixed — unilateral	34.00
	Restorative Services (includes liners, bases, and local anesthesia)	
02140	1 surface, permanent	13.00
02150	2 surfaces, permanent	20.75
02160	3 surfaces, permanent	27.50
02951	Reinforcement pins, each pin	8.25
	Endodontics (includes local anesthesia)	
03110	Pulp cap — direct	16.50
03310	Root canal therapy, one canal	96.75
03320	Root canal therapy, two canals	136.25
03330	Root canal therapy, three canals	178.00
03410	Apicoectomy	55.00
	Periodontics (includes local anesthesia)	
04320	Provisional splinting	81.25
04341	Periodontal scaling and root planing, per quadrant	13.00
04910	Periodontal maintenance procedures	13.00
	Crown and Bridge (includes local anesthesia)	
02510	Inlay, metallic — one surface	68.00
02710	Crown, resin (laboratory)	108.75
02720	Crown, resin with high noble metal	178.00
02740	Crown, porcelain/ceramic substrate	136.25
02750	Crown, porcelain fused to high noble metal	178.00
02752	Crown, porcelain fused to noble metal	178.00
02790	Crown, full cast high noble metal	149.50
02810	Crown, 3/4 cast metallic	102.25
02952	Cast post and core in addition to crown	68.00
02954	Prefabricated post and core in addition to crown	34.00
02980	Crown repair	13.00
02920	Recement crown	27.50
	Pontics (includes local anesthesia)	
06210	Cast high noble metal	82.50
06240	Porcelain fused to high noble metal	136.25
	Dentures (prosthetics)	
05110	Complete denture — maxillary (including necessary adjustments within 6 months)	239.75
05120	Complete denture — mandibular (including necessary adjustments within 6 months)	239.75
05130	Immediate denture — maxillary	272.50
05140	Immediate denture — mandibular	272.50
05211	Maxillary partial denture — resin base	217.75
05510	Repair, broken complete denture base	20.75
05520	Replace missing or broken teeth, complete denture (each tooth)	9.75

High Option Dental Benefits *continued*

What is covered *(continued)*

ADA Code	Description of Service	Allowance
	Dentures *(continued)*	
05630	Replace or repair broken clasp	40.50
05640	Replace broken teeth (per tooth)	13.00
05650	Add tooth to existing partial denture	34.00
05660	Additional clasp to existing denture	40.50
05710	Rebase complete maxillary denture	68.00
	Oral Surgery (includes local anesthesia)	
04210	Gingivectomy or gingivoplasty, per quadrant	102.50
04260	Osseous surgery, including flap entry and closure, per quadrant	137.50
07110	Extraction of single tooth	15.00
07120	Each additional tooth at same session	12.00
07210	Surgical extraction of erupted tooth	23.00
07285	Biopsy of oral hard tissue	34.00
07310	Alveoplasty in conjunction with extraction, per quadrant	44.00
07450	Removal of odontogenic cyst or tumor/lesion, diameter up to 1.25 cm	66.00
07510	Incision and drainage of abscess, intraoral soft tissue	13.00
07960	Frenulectomy (frenectomy or frenotomy) separate procedure	61.50
	Miscellaneous Services	
09110	Palliative treatment of dental pain, minor procedure	7.50
09220	General anesthesia, first 30 minutes	8.75
09221	Each additional 15 minutes	4.38
09310	Consultation by other than the attending dentist	20.75

Related benefits

PPO Benefit

The Plan offers access to a network of dentists who have agreed to provide services at a discounted rate. To learn of a preferred dentist in your area, contact 1-888-788-5702 or visit the Plan's website www.mhbp.com. For information about the Plan's benefits, call customer relations at 1-800-410-7778 or visit the Plan's website.

Hospitalization for dental treatment

Inpatient hospital benefits are available in connection with dental procedures only as provided on pages 13–14 and with precertification.

Accidental injury

Repair of sound, natural teeth following accidental injury (including, but not limited to expenses for X-rays, crowns, bridgework, or dentures) performed within 12 months of the accident, is covered under Surgical Benefits and Other Medical Benefits. This benefit for accidental injury to sound natural teeth is available to members enrolled under both the High and Standard Options. Masticating (chewing) incidents are not considered to be accidental injuries. See Emergency Treatment on page 23 for coverage of services related to accidental dental injury within 72 hours of an injury. There will be no exceptions to the 72-hour time limit.

Oral and maxillofacial surgery

For coverage of oral and maxillofacial surgery, including coverage for removal of impacted teeth, see pages 14–17.

What is not covered

- Charges related to orthodontia
- Oral hygiene instruction
- Denture replacements (if benefits were provided by this Plan within the last five years)
- Temporary dental services
- Dental implants or related surgical benefits
- Hospital charges for covered dental procedures unless the covered oral surgery was preauthorized
- Orthotics and other occlusal appliances used to treat temporomandibular joint dysfunction and/or sleep apnea

Non-FEHB Benefits Available to Plan Members

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

- **Vision One Eyecare Program** provides Plan enrollees and eligible dependents the ability to obtain eye exams, frames, eyeglasses, and contact lenses at reduced prices from Vision One providers. For more information concerning the Vision One Eyecare Program, you may call 1-800-424-1155 for the name of the eye care center closest to you.

- **Miracle-Ear Hearing Program** provides Plan enrollees and eligible dependents the ability to obtain free hearing tests and evaluations, free counseling, free check-up and cleaning of instruments, and a discount off of suggested retail prices of Miracle-Ear hearing aid products. Consult your Yellow Pages for the Miracle-Ear Center, Miracle-Ear at Montgomery Ward, Sears Hearing Aid Center or simply call the Miracle-Ear Consumer Affairs Department at 1-800-456-6801 for the location nearest you.

- **SDV Vitamins Discount Program** provides enrollees and eligible family members the ability to obtain vitamins, minerals, herbal formulas, weight management products, and over-the-counter pharmaceuticals at a 5% discount off the prices shown in the SDV Vitamins Catalogue. You may call toll-free 1-800-738-8482 to order a catalogue or to place an order. Be sure to mention code MHP02 to obtain the discount.

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

- **Hospital Money Plan** provides daily cash benefits for hospitalization. Cash payments of up to $100 per day are paid directly to enrollees when they or a covered family member are hospitalized for any covered sickness or accident. If confinement is for intensive care, benefits of up to $200 per day are paid. The money is paid directly to the enrollee and may be spent in any way. For additional information concerning the Hospital Money Plan, you may call 1-800-621-0839.

- **Off-Work Accident Disability Plan** provides $150 a week when an enrollee is totally disabled by an off-work injury. The program also provides up to $25,000 for accidental death benefits. If the enrollee has children, up to $10,000 in educational benefits for each eligible child is provided if death occurs as a result of a covered injury. For more information about the Off-Work Accident Disability Plan, you may call 1-800-621-0839.

- **Dental Supplement Plan** offers increased dental coverage to High Option enrollees and covered dependents. The Dental Supplement Plan will automatically increase benefits for covered diagnostic, preventive, and periodontal services by 60%; benefits for all other covered services will increase by 30%. Enrollees and covered dependents will also receive benefits for a second annual cleaning and exam. There is no deductible for this plan and no extra claim forms. For more information about the Dental Supplement Plan, you may call 1-800-621-0839.

- **Short-Term Disability Income Protection** provides up to $500 or $1,000 per month to enrollees to replace lost income for a period of up to 12 or 24 months as a result of a disability due to a covered illness, injury, or complications of pregnancy. The benefit choice and period is up to the enrollee. All enrollees under the age of 60 are guaranteed acceptance in this plan as long as they actively work at least 30 hours a week and have not been hospitalized in the last six months. For more information about this program, call 1-800-621-0839.

- **Group Long Term Care Program** is designed to help people cope with the potentially devastating costs associated with long term care. The Mail Handlers Group Long Term Care Program lets enrollees choose the type of care they receive and where they receive it, either in a nursing home, community setting, or at home. Long Term Care benefits are typically not provided by regular group health insurance, and Medicare benefits are limited, so coverage for long term care expenses can be an important financial decision. Complete information on the Mail Handlers Group Long Term Care Program, including a full explanation of rates and benefits, can be requested by visiting the MHBP website (www.mhbp.com) or a kit can be requested by calling 1-800-522-0100. This program is underwritten by Continental Casualty Company, a CNA company. (Not available in AR, AZ, MD and PA.)

Benefits on this page 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 Plan at 1-800-410-7778 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 Plan at 1-800-410-7778 or you may write to the Plan at: Mail Handlers Benefit Plan, P.O. Box 45118, Jacksonville, FL 32232-5118.

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. Claims submitted by enrollees may be submitted on the HCFA 1500 or a claim form that includes the information shown below. All claims should be completed in ink or type that is readable by an optic scanner. Non-readable claims will be returned unprocessed. Bills and receipts should be itemized and show:

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payor (such as Medicare or a group health insurance plan) must be sent with your claim.
- Bills for outpatient private-duty nurses must show that the nurse is a registered or licensed practical nurse and must include nursing notes.
- Claims for rental or purchase of durable medical equipment, outpatient 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. The Plan applies the exchange rate published for the date the services were rendered.
- All foreign claims payments will be made directly to the enrollee except for services rendered to beneficiaries of the Department of Defense third party collection program.

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

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

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

For prescription drug claims, see pages 26–28.

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 Plan will not provide duplicates or year-end statements.

How to file claims
(continued)

Submit claims promptly

Claims should be filed promptly after the expense is incurred for which the claim is being made. The Plan will not accept a claim submitted later than December 31st of the calendar year following the one in which the service or supply was received, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. 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

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

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

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

When more information is needed

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

Section 7. General Exclusions – Things We Don't Cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness or condition. The fact that one of our covered providers 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;
- 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;
- Services, drugs and supplies related to sex transformations, sexual dysfunction or sexual inadequacy, penile prosthesis;
- 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;
- Services and supplies for which there would be no charge if the covered individual had no health insurance coverage;
- Services and supplies furnished without charge while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as the result of an act of war within the Unites States, its territories or possessions, or (2) during combat;
- Services and supplies furnished by household members or immediate relatives, such as spouse, parents, grandparents, children, brothers or sisters by blood, marriage or adoption;
- Services and supplies furnished or billed by a non-covered facility except that medically necessary prescription drugs are covered;
- Services, drugs and supplies associated with care that is not covered, though they may be covered otherwise (e.g., Inpatient Hospital Benefits are not payable for non-covered cosmetic surgery);
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 38–39), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge) (see pages 35–37), or State premium taxes however applied;
- Services, drugs and supplies for weight control or treatment of obesity, except surgery for documented morbid obesity;
- Outpatient nutritional supplies that do not require a prescription and are not furnished in connection with a covered professional service or in connection with covered durable medical equipment;
- Educational, recreational or milieu therapy, whether in or out of the hospital;
- Services and supplies for cosmetic purposes, except as provided under Surgical Benefits/ Limited Benefits/Cosmetic Surgery;
- Biofeedback;
- Cardiac rehabilitation;
- Eyeglasses, contact lenses and hearing aids, except as provided under Additional Benefits;
- Orthotics and appliances used to treat temporomandibular joint dysfunction;
- Custodial care (see definition) or domiciliary care;
- Travel, even if prescribed by a doctor, except as provided under the Ambulance Benefit;
- Handling Charges/Administrative Charges or late charges, including interest, billed by providers of care; and
- Services and/or supplies not listed as covered in this brochure.

Section 8. Limitations – Rules That Affect Your Benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare and this Plan 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 the Plan; this applies whether or not you file a claim under Medicare. You must also give the Plan 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 Plan about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare (see pages 35–37).

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 payor 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 you are a Federal employee and you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

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;

Medicare *(continued)*

Medicare is primary if: *(continued)*

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 Parts 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 payor 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:

- When Medicare Part A (hospital) is primary, the Plan will waive applicable deductibles and coinsurance for Inpatient Hospital Benefits and Inpatient Mental Conditions/Substance Abuse Benefits.
- When Medicare Part B (medical) is primary, the Plan will waive applicable copayments and coinsurance for Surgical Benefits, Other Medical Benefits, Durable Medical Equipment, Orthopedic and Prosthetic Appliances, and Ambulance services. The calendar year deductible will be waived.
- The calendar year deductible will be waived, but the coinsurance will not be waived for Nursing Benefits and Outpatient Mental Conditions/Substance Abuse Benefits.
- The deductible, coinsurance and copayments for prescription drugs will not be waived.

When Medicare is the primary payor, 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 directly 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.

When you also enroll in a Medicare pre-paid plan

When you are enrolled in a Medicare pre-paid plan while you are a member of the 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.

Medicare *(continued)*

Medicare's payment and this Plan *(continued)*

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% 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 MSN form. In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115% of the Medicare approved amount.

How to claim benefits

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

Other Group Insurance Coverage and Automobile Insurance

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 even if we don't ask for them.

When there is double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. When this Plan is the secondary payor, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of covered expenses.

The determination of which coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). 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.

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

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. The Plan has the right to be reimbursed for benefits paid or payable on behalf of a Plan enrollee or a covered family member as the result of an illness or injury caused by a third party even if you were not made whole. When a Plan enrollee or a covered family member makes a damage claim against a third party or his or her uninsured or underinsured auto policy, as a result of an injury or illness, the Plan may assert a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement. A Plan enrollee or covered family member must cooperate in the assertion of the Plan's lien by giving an assignment of claim proceeds to the Plan, and by accepting the Plan's lien for the full amount of benefits paid or payable on behalf of the Plan enrollee or covered family member.

Liability insurance and third-party actions *(continued)*

The Plan will provide necessary forms including a Reimbursement Agreement and insist on written confirmation of the lien before paying any benefits on account of the illness or injury. Payment of benefits prior to the Plan being advised of the third-party claim does not waive the Plan's right to withhold benefits where an enrollee or covered family member has not cooperated in protecting the Plan's lien. No reduction in the Plan's lien can occur without the Plan's written consent. Failure to notify the Plan promptly of the claim for damages or to cooperate with the Plan's reimbursement efforts may result in an overpayment by the Plan 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.

Medicaid

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

Other Government Agencies

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

Overpayments

The Plan 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.

Vested Rights

An enrollee does not have a vested right to 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 the brochure.

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

The information in the 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 charges. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

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

Inpatient hospital care *(continued)*

The Plan'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 1-800-410-7778 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 processed in accordance with 5 U.S.C. 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 charges, whichever is lower.

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 physician services benefit, the Plan will pay 70% of the Medicare-approved amount. You will only be responsible for the coinsurance equal to 30% 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 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-approved 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 Plan'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 1-800-410-7778.

Section 9: Fee-for-Service 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 the Plan at least two working days before admission. The toll-free number is 1-800-410-7778.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date, and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

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

Need additional days?

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional inpatient days are medically necessary. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for inpatient room and board charges incurred on any extra days that are determined to not be medically necessary by the Plan during the claim review. All maternity claims admissions that are not certified for additional days beyond 48 hours after a regular delivery or 96 hours after cesarean section will be subject to the precertification penalty.

You don't need to certify an admission when:

- Medicare Part A or another group health insurance policy is the primary payor for the hospital confinement (see pages 35–37). 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.
- Your stay is less than 23 hours.
- When the discharge for your maternity admission is within 48 hours after a regular delivery or within 96 hours after a cesarean section delivery.

Emergency admissions

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

Newborn confinements 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 confinement within two business days following the day of the mother's discharge.

Other considerations

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

Precertification *continued*

If you do not precertify

If precertification is not obtained before admission to the hospital or after 48 hours after a regular delivery or 96 hours after a cesarean section delivery (or within two business days following the day of an 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 Plan determines that the hospitalization was not medically necessary the inpatient hospital room and board benefits will not be paid. However, medically necessary hospital services and supplies otherwise payable will be considered by the Plan at 70% of actual charges.

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 room and board hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medically necessary services and supplies otherwise payable will be considered by the Plan at 70% of actual charges.

Protection Against Catastrophic Costs

Catastrophic protection

The Plan pays 100% of reasonable and customary eligible charges for the remainder of the calendar year when out-of-pocket expenses in that calendar year exceed $4,000 under High and Standard Option for you and any covered family members. Under family coverage, out-of-pocket expenses for family members accumulate towards one $4,000 maximum.

PPO Providers: When your eligible out-of-pocket expenses from using PPO providers (when the services are eligible to be received from PPO providers) exceed $2,500 under the High Option, the Plan pays 100% of its covered charges for covered expenses when you continue to select PPO providers for the remainder of the calendar year. Whether or not you use PPO providers, your share of out-of-pocket expenses will not exceed $4,000 in a calendar year.

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

- The 30% (Non-PPO) coinsurance you pay for surgery (including obstetrical care); anesthesia; doctors' inpatient and outpatient medical visits; outpatient diagnostic laboratory tests, X-rays and machine tests; outpatient accidental injury and emergency illness treatment; ambulance; outpatient surgical facility charges; outpatient chemotherapy, X-ray or radium treatment, hemodialysis, peritoneal dialysis, and hyperbaric oxygen therapy; durable medical equipment; and dental work if required for repair of an accidental injury.
- The 10% (PPO) coinsurance you pay for surgery (including obstetrical care); anesthesia; doctors' inpatient medical visits; outpatient diagnostic laboratory tests, X-rays and machine tests; outpatient accidental injury and emergency illness treatment; outpatient chemotherapy, X-ray or radium treatment, hemodialysis, peritoneal dialysis, and hyperbaric oxygen therapy; durable medical equipment; and dental work if required for repair of an accidental injury.

The following cannot be included in the accumulation of out-of-pocket expenses or covered under this benefit:

- Copayments;
- Coinsurance for chiropractor visits; physical, speech, occupational, and acupuncture therapy; nursing services;
- Deductibles;
- Non-covered services and supplies;
- Expenses in excess of reasonable and customary charges or benefit maximums;
- Expenses for diagnosis/treatment of mental conditions or substance abuse, hospice care, nursing care, prescription drugs, or dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with the Plan's precertification requirements.

Definitions

Accidental injury

An injury caused by an external force such as a blow or a fall that requires immediate attention. Also included are animal bites, poisonings, and dental care required as a result of an accidental injury to sound natural teeth. An injury to the teeth while eating is not considered an accidental injury.

Admission

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

Assignment

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

Calendar year

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

Congenital anomaly

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

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 Plan determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

1) are prescribed by your attending doctor;
2) are medically necessary;
3) are primarily and customarily used only for a medical purpose;
4) are generally useful only to a person with an illness or injury;
5) are designed for prolonged use; and
6) serve a specific therapeutic purpose in the treatment of an illness or injury.

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.

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.

Definitions *continued*

Hospice care program

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

Medically necessary

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

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

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

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 Plan; 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 100 pounds or 100% over his or her normal weight (in accordance with current underwriting standards). Eligible members must be age 18 or over.

Orthopedic appliance

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

Prosthetic appliance

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

Reasonable and customary

The medical benefits of this Plan are limited to, and based on, reasonable and customary charges, except for negotiated rates with PPO providers, network retail pharmacies and an average PPO schedule for services and supplies where access to a PPO network provider (i.e., the negotiated rate) was available but not utilized.

The reasonable and customary charge for any Non-PPO services or supplies generally is the lesser of either (a) the usual charge made by the provider for the service or supply in the absence of insurance or, (b) the charge that the Plan determines to be in the 80th percentile of the prevailing charges made for the service or supply in the geographic area in which it is furnished. The prevailing charge data is collected by the Plan's underwriter. For certain services, exceptions to the general method of determining reasonable and customary may exist.

The average PPO schedule for any Non-PPO services or supplies is based on the average of the medical PPO provider negotiated fee schedules in a particular geographic area for a particular service or supply. The average PPO fee schedule applies in cases where adequate access to a PPO network provider (i.e., the negotiated rate) was available to the patient, but the patient did not use a medical PPO provider to perform the service or provide the supply.

Scooters

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

Section 10. FEHB Facts

You Have a 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 (http://www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-800-410-7778, or write to the Mail Handlers Benefit Plan, P.O. Box 45118, Jacksonville, FL 32232-5118. You may also visit our website (http://www.mhbp.com).

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.

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

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

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

You Have a Right to the Following Information *continued*

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 benefits and subrogating claims,
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity,
- OPM, when reviewing a disputed claim or defending litigation about a claim, or
- PCS, Health International, First Health or any other subcontractor of the Plan who is engaged in helping the Plan measure healthcare quality and customer satisfaction. The data they gather will be used solely in the administration of the Plan.

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 FEHB 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.

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you cannot 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.

When You Lose Benefits *continued*

Key points about TCC:

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

How do I enroll in TCC?

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

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

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

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

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

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

How can I convert to individual coverage?

You may convert to an individual policy if:

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

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

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

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

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

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

Department of Defense/FEHBP Demonstration Project

What is the Department of Defense (DoD)/FEHBP 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 military 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 FEHBP. 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-FEHBP (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.

DoD has a website 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 website at www.opm.gov.

Department of Defense/FEHB Demonstration Project *continued*

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/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/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.

Inspector General Advisory: Stop Health Care Fraud!

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

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

THE HEALTH CARE FRAUD HOTLINE

202-418-3300

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

Penalties for Fraud

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

Index

Summary of Standard Option Benefits for the Mail Handlers Benefit Plan — 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 per person calendar year deductible.

		Standard Option pays	Page
Inpatient care	**Hospital**	**PPO benefit:** After $150 per-admission deductible, 100% of covered charges **Non-PPO benefit:** After $300 per-admission deductible, 100% of covered charges	13–14 13–14
	Surgical	**PPO benefit:** 90%* of covered charges **Non-PPO benefit:** 70%* of R&C charges	14–17 14–17
	Medical	**PPO benefit:** 90%* of covered charges **Non-PPO benefit:** 70%* of R&C charges	21–24 21–24
	Maternity	Same benefits as illness or injury	17–19
	Mental Conditions/ Substance Abuse	**PPO benefit:** After $150 per-admission deductible, 70% of covered charges up to 45 days per calendar year **Non-PPO benefit:** After $300 per-admission deductible, 70% of covered charges up to 45 days per calendar year	20–21 20–21
Outpatient care	**Hospital**	**PPO:** 90%* of covered charges for facility charges related to chemotherapy, hemodialysis, and radiation therapy **Non-PPO:** 70%* of R&C charges for facility charges related to chemotherapy, hemodialysis, and radiation therapy	21–22 21–22
	Surgical	**PPO benefit:** 90%* of covered charges billed by primary surgeon; 100%* of covered charges billed by surgery facility **Non-PPO benefit:** 70%* of R&C charges billed by primary surgeon; 70%* of covered charges billed by surgery facility	22 22
	Medical	**PPO benefit:** 100% of covered charges after a $15 copayment for doctors' medical visits and a $5 copayment for allergy injections; 90%* of covered charges for diagnostic X-rays, laboratory services and other outpatient visits **Non-PPO benefit:** 70% of R&C charges for doctors' medical visits; 70%* of R&C charges for diagnostic X-ray, laboratory services and other outpatient visits **Performance Lab:** 100% of covered charges for services provided under the Performance Lab Program	21–24 21–24 23
	Maternity	Same benefits as illness or injury	17–19
	Home Health Care	No current benefit.	
	Mental Conditions/ Substance Abuse	70%* of R&C charges, limited to 20 visits per year	20–21
Emergency care		**PPO benefit:** 90%* of covered charges for outpatient treatment of accidental injury or medical emergency within 72 hours of the occurrence **Non-PPO benefit:** 70%* of reasonable and customary charges for outpatient treatment of accidental injury or medical emergency within 72 hours of the occurrence	23 23
Prescription drugs		After $600 per person calendar year prescription drug deductible: **PCS:** 70% of PCS charges; **Non-PCS:** 50% of PCS charges; **Mail Order:** $10 copayment per generic prescription ($40 preferred brand; $55 non-preferred brand)	26–28
Dental care		No current benefit.	
Additional Benefits		Eyeglasses following accident or surgery, hospice, ambulance, hearing aid following accident, durable medical equipment, home nursing services, orthopedic and prosthetic devices, rabies shots	25–26
Catastrophic protection		100% of covered charges when applicable coinsurance reaches $4,000 per calendar year	41

Summary of High Option Benefits for the Mail Handlers Benefit Plan — 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 $150 per person calendar year deductible.

		High Option pays	Page
Inpatient care	**Hospital**	**PPO benefit:** 100% of covered charges, no deductible **Non-PPO benefit:** After $250 per-admission deductible, 100% of covered charges	13–14 13–14
	Surgical	**PPO benefit:** 90%* of covered charges **Non-PPO benefit:** 70%* of R&C charges	14–17 14–17
	Medical	**PPO benefit:** 90%* of covered charges **Non-PPO benefit:** 70%* of R&C charges	21–24 21–24
	Maternity	Same benefits as illness or injury	17–19
	Mental Conditions/ Substance Abuse	**PPO benefit:** 70% of covered charges up to 45 days per calendar year **Non-PPO benefit:** After $250 per-admission deductible, 70% of covered charges up to 45 days per calendar year	20–21 20–21
Outpatient care	**Hospital**	**PPO benefit:** 90%* of covered charges for facility charges related to chemotherapy, hemodialysis, and radiation therapy **Non-PPO benefit:** 70%* of R&C charges for facility charges related to chemotherapy, hemodialysis, and radiation therapy	21–22 21–22
	Surgical	**PPO benefit:** 90%* of covered charges billed by primary surgeon; 100%* of covered charges billed by surgery facility **Non-PPO benefit:** 70%* of R&C charges billed by primary surgeon; 70%* of covered charges billed by surgery facility	22 22
	Medical	**PPO benefit:** 100% of covered charges after a $15 copayment for doctors' medical visits and a $5 copayment for allergy injections; 90%* of covered charges for diagnostic X-rays, laboratory services and other outpatient visits **Non-PPO benefit:** 70% of R&C charges for doctors' medical visits; 70%* of R&C charges for diagnostic X-ray, laboratory services and other outpatient visits **Performance Lab:** 100% of covered charges for services provided under the Performance Lab Program	21–24 21–24 23
	Maternity	Same benefit as illness or injury	17–19
	Home Health Care	No current benefit.	
	Mental Conditions/ Substance Abuse	70%* of R&C charges, limited to 20 visits per year	20–21
Emergency care		**PPO benefit:** 90%* of covered charges for outpatient treatment of accidental injury or medical emergency within 72 hours of the occurrence **Non-PPO benefit:** 70%* of reasonable and customary charges for outpatient treatment of accidental injury or medical emergency within 72 hours of the occurrence	23 23
Prescription drugs		After $250 per person calendar year prescription drug deductible: **PCS:** 75% of PCS charges; **Non-PCS:** 50% of PCS charges; **Mail Order:** $10 copayment per generic prescription ($30 preferred brand; $45 non-preferred brand)	26–28
Dental care		Up to amount stated in the schedule of dental allowances (maximum benefit of $800 per person, $1,600 per family each calendar year)	28–30
Additional Benefits		Eyeglasses following accident or surgery, hospice, ambulance, hearing aid following accident, durable medical equipment, home nursing services, orthopedic and prosthetic devices, rabies shots	25–26
Catastrophic protection		100% of covered charges when applicable coinsurance reaches $2,500 per calendar year when PPO providers are used and $4,000 when they are not	41

2000 Rate Information for Mail Handlers Benefit Plan

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

Postal rates apply to most 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 employee, who is 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 rates applies to you.

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

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
High Option Self Only	**451**	**$78.83**	**$45.43**	**$170.80**	**$98.43**	**$93.06**	**$31.20**	**$93.26**	**$31.00**
High Option Self and Family	**452**	**$175.97**	**$86.13**	**$381.27**	**$186.61**	**$207.74**	**$54.36**	**$201.02**	**$61.08**
Standard Option Self Only	**454**	**$63.25**	**$21.08**	**$137.04**	**$45.68**	**$74.84**	**$9.49**	**$74.84**	**$9.49**
Standard Option Self and Family	**455**	**$137.28**	**$45.76**	**$297.44**	**$99.15**	**$162.45**	**$20.59**	**$162.45**	**$20.59**