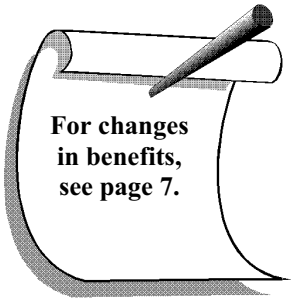
Mail Handlers Benefit Plan

http://www.mhbp.com

2003

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

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



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

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

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

Enrollment codes for this Plan:

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

URAC ACCREDITED
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First Health
Health Utilization Management
Disease Management

See the 2003 Guide for more information on accreditation.

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UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
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FEHB
Federal Employees
Health Benefits Program

GCIU

RI 71-007

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

This brochure describes the benefits of the Mail Handlers Benefit Plan. The National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO has entered into a contract (CS1146) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefit law. This Plan is underwritten by First Health Life and Health Insurance Company/Cambridge Life Insurance Company. The address for the administrative offices is:

Mail Handlers Benefit Plan
P.O. Box 44242
Jacksonville, Florida 32231-4242

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized Plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 1-800-410-7778 and explain the situation.
    - If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

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

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

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

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

Preferred Provider Organizations (PPO)

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

The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the regular non-PPO benefits apply. If you receive non-covered services from a PPO provider, the PPO discount will not apply and these services will be excluded from coverage. The nature of the services (such as urgent or emergency situations) does not affect whether benefits are paid as PPO or non-PPO.

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

Managed Network Providers

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

MultiPlan Participating Providers

This Plan has a contract with MultiPlan. MultiPlan has entered into contracts with non-PPO hospitals/facilities that have agreed to discount their charges. The Plan will consider these hospitals/facilities as participating providers. Covered inpatient medical hospital claims will be considered at 100% of the negotiated amount, subject to the applicable per-admission copayment. Covered outpatient services at participating MultiPlan hospitals/facilities are considered at the MultiPlan negotiated rate less any applicable deductibles and coinsurance. Since MultiPlan hospitals/facilities are not PPO providers, non-PPO benefit levels will apply.

Dental PPOs

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

How we pay providers

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

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

If PPO providers are available where you receive care and you do not use them, your out-of-pocket expenses will increase. The Plan will base its allowance on a fee schedule that represents an average of the PPO fee schedules for a particular service in a particular geographic area (see definition of Plan allowance, page 73, for further details).

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

Your Rights

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

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

If you want more information about us, call 1-800-410-7778, or write to: Mail Handlers Benefit Plan, P.O. Box 44242, Jacksonville, FL, 32231-4242. You may also visit our web site at www.mhbp.com.

Section 2. How we change for 2003

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

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- The Medically Underserved section is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal High Option Self Only premium will increase by 16.7%. For High Option Self and Family your share will increase by 17.5%.
- Your share of the non-Postal Standard Option Self Only premium will increase by 9.5%. For Standard Option Self and Family your share will increase by 9.5%.
- We increased the calendar year deductible for High Option from $200 to $250 per person and from $600 to $750 per family. This applies to services and supplies for both medical and mental health/substance abuse.
- We increased the calendar year deductible for Standard Option from $250 to $300 per person and from $750 to $900 per family. This applies to services and supplies for both medical and mental health/substance abuse.
- We increased the Standard Option copayment for PPO physician's visits from $15 to $18 per visit.
- We changed how you pay for prescription drugs purchased at a retail pharmacy from coinsurance to copayments. Under High Option, you pay $7 per prescription for generic, $23 per prescription for preferred brand name, and $35 for non-preferred brand name drugs. Under Standard Option, you pay $8 per prescription for generic, $28 per prescription for preferred brand name, and $40 for non-preferred brand name drugs. Previously, you paid 25% coinsurance under High Option and 30% coinsurance under Standard Option. The applicable calendar year deductible still applies.
- We changed the dispensing limitation for prescription drugs purchased at a retail pharmacy from up to a 90-day supply to up to a 30-day supply.
- We will waive the full prescription drug deductible for retail pharmacy purchases for High Option members who have Medicare Parts A and B as their primary coverage.
- We will waive $300 of the prescription drug deductible for retail pharmacy purchases for Standard Option members who have Medicare Parts A and B as their primary coverage.
- We increased the High Option catastrophic protection out-of-pocket limit for coinsurance from $2,500 to $3,000 for PPO services, and from $4,000 to $6,000 for any combination of PPO and non-PPO services.
- We increased the Standard Option catastrophic protection out-of-pocket limit for coinsurance from $4,000 to $6,500 for any combination of PPO and non-PPO services. The limit will remain at $4,000 for PPO services.
- We added a national transplant program, see Section 5(b).
- We added coverage to colorectal cancer screening for one colonoscopy every 10 years for all members age 50 and over.
- We changed the Rehabilitative therapies benefit to include in the annual $2,000 maximum any services and supplies billed by a doctor of osteopathy (D.O.).
- We discontinued the Worldwide Assistance program. It has been replaced by **First Health**® OnCall.

Other Changes

- Our voluntary laboratory service program is now called the **First Health**® Lab Program. Services for this program are still provided by Quest Diagnostics.
- The address for filing claims for Medical/Dental and for Prescription Drug benefits has changed, see Section 7.
- We clarified the exclusion for outpatient chelation therapy to show that any related services are also not covered.

Section 3. How you get benefits

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-410-7778 or write to us at Mail Handlers Benefit Plan, P.O. Box 44242, Jacksonville, FL, 32231-4242. You may also request replacement cards through our web site: www.mhbp.com.

Where you get covered care

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

- **Covered providers**

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

- a licensed doctor of medicine (M.D.)
- a licensed doctor of osteopathy (D.O.)
- a licensed doctor of podiatry (D.P.M.)
- a licensed dentist
- a chiropractor
- a licensed registered physical therapist (R.P.T.)
- a licensed occupational therapist
- a licensed speech therapist
- a clinical psychologist
- a clinical social worker
- an optometrist
- an audiologist
- an acupuncturist
- a physician's assistant
- a nurse midwife
- a nurse practitioner/clinical specialist
- a nursing school-administered clinic

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2003, the states are: Alabama, , Idaho, Kentucky, Louisiana, Maine, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, West Virginia and Wyoming.

- **Covered facilities**

Covered facilities include:

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

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

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

  (c) a licensed birthing center.

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

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

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

  (c) is operated as a school; or

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

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

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

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

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

  (e) provides an ongoing quality assurance program.

What you must do to get covered care

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

Transitional care:

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

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

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

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

Hospital care:

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer relations department immediately at 1-800-410-7778.

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

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

These provisions apply only to the hospitalized person.

How to get approval for…

• Your hospital stay

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

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

Warning:

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

Any stay greater than 23 hours must be precertified.

How to precertify an admission

- You, your representative, your doctor, or your hospital must call the Plan at least two working days before admission. The toll-free number is 1-800-410-7778.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date and phone number;
  - Reason for hospitalization, proposed treatment or surgery;
  - Name of hospital or facility;
  - Name and phone number of admitting doctor; and
  - Number of planned days of confinement.
- We will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Plan's certification decision will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Maternity care

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

If your hospital stay is extended

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

What happens when you do not follow the precertification rules

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

Exceptions

You do not need precertification in these cases:

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

• Other services

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

- This Plan requires preauthorization of mental health/substance abuse services under the managed In-Network benefit. See Section 5(e).
- This Plan requires preauthorization of certain drugs. See Section 5(f).
- This Plan requires prior authorization of transplant services under the National Transplant Program. You or your physician must call 1-800-410-7778 to speak with a transplant case manager prior to your pre-transplant evaluation as a potential candidate for a transplant procedure. See Section 5(b).

Section 4. Your costs for covered services

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

• Copayments

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

Example: When you see your PPO physician you pay a copayment of $18 per visit for Standard Option or $15 per visit for High Option.

• Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. Copayments and coinsurance do not count toward any deductible.

- The calendar year deductible for covered medical services and supplies is $250 per person under High Option and $300 per person under Standard Option. Under a family enrollment, the medical services and supplies deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $750 under High Option and $900 under Standard Option.
- The calendar year deductible for covered mental health/substance abuse services is $250 per person under High Option and $300 per person under Standard Option. This deductible is in addition to the medical services deductible. Under a family enrollment, the mental health/substance abuse services deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible reach $750 under High Option and $900 under Standard Option.
- The calendar year deductible for prescription drugs is $250 per person under High Option and $600 per person under Standard Option. Under a family enrollment, this deductible is met when the family has incurred $500 under High Option and $1,200 under Standard Option.

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

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

• Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

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

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

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

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

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

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

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

MultiPlan hospitals/facilities agree to limit what they can collect from you. You will still have to pay your deductible and coinsurance. These providers agree to write off the difference between billed charges and the discount amount.

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

HIGH OPTION

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

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

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

- $3,000 for services of PPO providers/facilities under the High Option
- $4,000 for services of PPO providers/facilities under the Standard Option
- $6,000 for services of PPO and Non-PPO providers/facilities, combined, under the High Option.
- $6,500 for services of PPO and Non-PPO providers/facilities, combined, under the Standard Option.

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

- $3,000 for services of In-network providers/facilities under the High Option
- $4,000 for services of In-network providers/facilities under the Standard Option

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

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

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

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

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

When government facilities bill us

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

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

If we overpay you

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

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

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

If you…

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

Then, for your inpatient hospital care,

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

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

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

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

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

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

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

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

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

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

- When Medicare Part A is primary, the Plan will waive applicable per-admission copayments and coinsurance for Inpatient Hospital Benefits and Inpatient Mental Health/Substance Abuse Benefits
- When Medicare Part B is primary, the Plan will waive applicable deductibles, copayments and coinsurance for surgical and medical services billed by physicians, durable medical equipment, orthopedic and prosthetic appliances, and ambulance services.
- When Medicare Part B is primary, the Plan will waive the calendar year deductible (but not the coinsurance) for nursing benefits and outpatient mental health/substance abuse benefits.
- When Medicare Parts A and B are primary, the Plan will waive the full deductible for prescription drugs purchased through the mail order prescription drug program for both High Option and Standard Option.
- When Medicare Parts A and B are primary, the Plan will waive the full High Option prescription drug deductible for prescription drugs purchased at a retail pharmacy.
- When Medicare Parts A and B are primary, the Plan will waive $300 of the Standard Option prescription drug deductible for prescription drugs purchased at a retail pharmacy.

Note: The Plan will not waive the copayment and coinsurance for retail or mail order prescription drugs.

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

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

Section 5. Benefits – OVERVIEW

(*See page 7 for how our benefits changed this year and pages 79-80 for a benefits summary.)*

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

Treatment therapy	You Pay — Standard Option	You Pay — High Option
• Chemotherapy and radiation therapy for treatment of cancer. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 38. • Dialysis — hemodialysis and peritoneal dialysis • Intravenous (IV)/Antibiotic Infusion Therapy • Hyperbaric oxygen therapy • Treatment room • Observation room Note: These therapies (excluding the related office visits) are covered under this benefit when billed by the outpatient section of a hospital, clinic or a physician's office. Retail pharmacy charges for chemotherapy and prescription drugs to treat the side effects of chemotherapy are covered under Prescription Drugs, see Section 5(f).	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Rabies shots and related services	Nothing	Nothing
Not covered: • *Chelation therapy and related services, except if the covered services and supplies are provided during a precertified inpatient admission* • *Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered under Section 5(b)*	*All Charges*	*All Charges*

Section 5. Benefits – OVERVIEW

(*See page 7 for how our benefits changed this year and pages 79-80 for a benefits summary.)*

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Rabies shots and related services	Nothing	Nothing
Not covered: • *Chelation therapy and related services, except if the covered services and supplies are provided during a precertified inpatient admission* • *Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered under Section 5(b)*	*All Charges*	*All Charges*

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($900 per family) for Standard Option and $250 per person ($750 per family) for High Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. See Section 4 for more information about deductibles and other cost-sharing features such as coinsurance and copayments.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You Pay After the calendar year deductible …	
	Standard Option	High Option
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**You Pay – Standard Option**	**You Pay – High Option**
Professional services of physicians • In physician's office (this includes evaluation and management services related to chemotherapy, hemodialysis and radiation therapy) • At home • In an urgent care center • Office medical consultations • Second surgical opinions provided in a physician's office	PPO: $18 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $15 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Same-day services performed and billed in conjunction with the office visit (except allergy shots, rabies shots or routine immunizations)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Diagnostic and treatment services – continued on next page

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($900 per family) for Standard Option and $250 per person ($750 per family) for High Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. See Section 4 for more information about deductibles and other cost-sharing features such as coinsurance and copayments.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You Pay After the calendar year deductible …	
	Standard Option	High Option
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**You Pay – Standard Option**	**You Pay – High Option**
Professional services of physicians • In physician's office (this includes evaluation and management services related to chemotherapy, hemodialysis and radiation therapy) • At home • In an urgent care center • Office medical consultations • Second surgical opinions provided in a physician's office	PPO: $18 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $15 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Same-day services performed and billed in conjunction with the office visit (except allergy shots, rabies shots or routine immunizations)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Diagnostic and treatment services – continued on next page

Diagnostic and treatment services *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Professional services of physicians during a hospital stay Note: Outpatient cancer treatment (chemotherapy, X-rays, or radiation therapy) and dialysis services are paid under Treatment therapy, page 25.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: • *Routine physical checkups and related tests except those covered under preventive care* • *Thermography and related visits* • *Chelation therapy and related services provided in an outpatient setting* • *Orthoptic visits and related services*	*All Charges*	*All Charges*
Lab, X-ray, and other diagnostic tests		
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.
First Health® Lab Program You can use this voluntary program for covered lab tests if this Plan is your primary insurance carrier. You show your Mail Handlers Benefit Plan identification card and ask your doctor to send your lab order to Quest Diagnostics. As long as Quest Diagnostics does the testing, you will not have to file any claims. To learn of a location near you, call 1-800-377-7220, or visit the Plan's web site at www.mhbp.com.	Nothing (No deductible)	Nothing (No deductible)
Not Covered: • *Handling and administrative charges* • *Routine lab services except as covered under Preventive care*	*All charges*	*All charges*

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

Preventive care, children	You Pay — Standard Option	You Pay — High Option
Routine childhood immunizations recommended by the American Academy of Pediatrics for members under age 22	PPO: Nothing (No deductible) Non-PPO: The difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: The difference between our allowance and the billed amount (No deductible)
Well-child office visits to a doctor for covered dependents up to age 18 Note: This benefit covers the office visit only, not any related services.	PPO: $18 copayment per office visit (No deductible). All charges after the Plan has paid $100 per child per calendar year. Non-PPO: All charges after the Plan has paid $75 per child per calendar year (No deductible)	PPO: $15 copayment per office visit (No deductible). All charges after the Plan has paid $100 per child per calendar year. Non-PPO: All charges after the Plan has paid $75 per child per calendar year (No deductible)
Routine screenings, limited to: • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: *Routine testing not specifically listed as covered*	*All Charges*	*All Charges*

Maternity care	You Pay — Standard Option	You Pay — High Option
Complete maternity (obstetrical) care, including: • Pre-natal care • Delivery • Anesthesia • Post-natal care Note: Here are some things to keep in mind: • You do not need to precertify your admission for a normal delivery; see page 11 for other circumstances such as extended stays for you or your baby. • You may remain in the hospital/birthing center up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you, your representative, your doctor or your hospital must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon's services (delivery and newborn circumcision) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)). • Newborn exams are payable under Section 5(a). • Newborn charges incurred as a result of illness, are considered expenses of the child, not the mother, and are subject to a separate precertification and separate inpatient copayment. • Maternity benefits will be paid at the termination of pregnancy.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not Covered: • *Standby doctors* • *Home uterine monitoring devices* • *Services provided to the newborn if the infant is not covered under a self and family enrollment*	*All Charges*	*All Charges*

Family planning	You Pay — Standard Option	You Pay — High Option
Voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures, Section 5(b)) • Surgically implanted contraceptives • Intrauterine devices (IUDs)	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
• Injectable contraceptive drugs (such as Depo-Provera) Note: We cover oral contraceptive drugs under the prescription drug benefit, Section 5(f).	PPO: $18 copayment per office visit (No deductible), and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (calendar year deductible applies)	PPO: $15 copayment per office visit (No deductible), and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (calendar year deductible applies)
Not covered: • *Reversal of voluntary surgical sterilization*	*All Charges*	*All Charges*
Infertility services		
Diagnosis and treatment of infertility, except as shown in *Not covered* Note: Certain prescription drugs for the treatment of infertility are covered under Prescription drug benefits. Call the Plan for a list of drugs that are covered for this service, or go to www.mhbp.com for a link to the list.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures such as:* – *artificial insemination* – *in vitro fertilization* – *embryo transfer and Gamete Intrafallopian Transfer (GIFT)* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or egg*	*All Charges*	*All Charges*

Allergy care	You Pay — Standard Option	You Pay — High Option
Testing, including materials	PPO: $18 copayment per office visit (No deductible), and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (calendar year deductible applies)	PPO: $15 copayment per office visit (No deductible), and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (calendar year deductible applies)
Allergy serum	PPO: $5 copayment (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $5 copayment (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Allergy injections (not including allergy serum)	PPO: $5 copayment per visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: $5 copayment per visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: *Any services or supplies considered by the National Institute of Health and the National Institute of Allergy and Infectious Disease to be not effective to diagnose allergies and/or not effective in preventing an allergy reaction*	*All Charges*	*All Charges*

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

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

Foot care	You Pay — Standard Option	You Pay — High Option
We pay the professional services for routine foot care for established diabetics. We also pay for medically necessary surgeries under the surgery benefit. See Section 5(b).	PPO: $18 copayment per office visit (No deductible), and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (calendar year deductible applies)	PPO: $15 copayment per office visit (No deductible), and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount for the office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services performed during the visit (calendar year deductible applies)
Not Covered: *Cutting, trimming and removal of corns, calluses or the free edge of toenails, and similar routine treatment of conditions of the foot except for the established diagnosis of diabetes*	*All Charges*	*All Charges*
Orthopedic and prosthetic devices		
Orthopedic and prosthetic devices (see Definitions — Section 10) when recommended by an MD or DO, including: • Artificial limbs and eyes, stump hose; • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy; • Internal prosthetic devices if billed by other than a hospital Note: Call the Plan to locate a vendor.	10% of the Plan's allowance	10% of the Plan's allowance
Not Covered: • *Orthopedic and corrective shoes unless attached to a brace* • *Arch supports* • *Foot orthotics and related office visits* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered unless a replacement is needed for medical reasons* • *Penile prosthetics*	*All Charges*	*All Charges*

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

Durable medical equipment – continued on next page

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

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

Alternative treatment	You Pay — Standard Option	You Pay — High Option
Acupuncture Note: The annual $2,000 combined rehabilitative, chiropractic and alternative treatment therapies maximum includes all covered services and supplies billed for these therapies.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the $2,000 combined rehabilitative, chiropractic and alternative treatment therapy maximum.
Not covered: • *Naturopathic and homeopathic services* • *Chelation therapy and related services, except if the covered services and supplies are provided during a precertified inpatient hospitalization* • *Thermography,* biofeedback *and related visits* • *Charges after the $2,000 combined rehabilitative, chiropractic therapies and alternative treatments annual maximum has been paid by the Plan* *Note: Services of certain alternative treatment providers may be covered in medically underserved areas — see page 8.*	*All Charges*	*All Charges*
Educational classes and programs		
Smoking Cessation — Up to $100 for one smoking cessation program per member per lifetime Note: All benefits are paid directly to you. Smoking deterrents are covered under prescription drugs. See Section 5(f).	All charges over $100	All charges over $100
Not Covered: • *Self help or self management programs such as diabetic self management* • *Charges for educational/instructional advice on how to use durable medical equipment*	*All Charges*	*All Charges*

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($900 per family) for Standard Option and $250 per person ($750 per family) for High Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. See Section 4 for more information about deductibles and other cost-sharing features such as coinsurance and copayments.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgery. Look in Section 5(c) for charges associated with the facility charge (i.e. hospital, surgical center, etc.).
- **PLEASE REMEMBER THAT ANY SURGICAL SERVICES THAT REQUIRE AN INPATIENT ADMISSION MUST BE PRECERTIFIED .** Please refer to the precertification information shown in Section 3.

IMPORTANT

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

Surgical procedures – continued on next page

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

Surgical Procedures – continued on next page

Surgical procedures *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Co-surgeons When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 50% of what it would pay a single surgeon for the same procedure(s).	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Assistant surgeon Assistant surgical services provided by a qualified surgeon (M.D.) when necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan will reduce its benefits for the assistant surgeon to 20% of the allowance for the surgery.	PPO: Nothing Non-PPO: The difference between our allowance and the billed amount	PPO: Nothing Non-PPO: The difference between our allowance and the billed amount
Not covered: • *Multiple or bilateral surgical procedures performed through the same incision that are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.* • *Reversal of voluntary sterilization* • *Services of a standby surgeon* • *Routine treatment of conditions of the foot except for services rendered to established diabetics* • *Cosmetic surgery (See definition, page 36)* • *Radial keratotomy, laser and other refractive surgery* • *Assistant surgeon services from a non-physician provider, such as a Physician Assistant (P.A.), Certified Nurse First Assistant (C.R.N.F.A.) and a Certified Surgical Technologist (C.S.T.)*	*All Charges*	*All Charges*

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

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

Organ/tissue transplants	You Pay — Standard Option	You Pay — High Option
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Kidney/Pancreas • Single lung • Double lung • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. • Allogenic (donor) bone marrow transplants for chronic myelogenous leukemia, acute leukemia, aplastic anemia, severe combined immuno-deficiency disease, Wiscott-Aldrich syndrome, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphomas, and myelodysplastic syndrome (in advanced form). • Autologous (self) bone marrow transplants (autologous stem cell and peripheral stem cell support) for chronic or acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphomas; resistant or recurrent neuroblastoma; testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer. • Autologous tandem bone marrow transplants for testicular and other germ cell tumors. Note: Corneal transplants are not part of the National Transplant Program. Benefits will paid as described above as PPO or Non-PPO services. Note: We cover related medical and hospital expenses of the donor when we cover the recipient, if not covered under any other health plan. Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support, is covered only for the specific diagnoses listed.	National Transplant Program: 10% of the Plan's allowance and all charges over $1,000,000. PPO: 15% of the Plan's allowance and all charges over $200,000. Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $100,000. Note: National Transplant Program participants – the Plan may approve reasonable travel, lodging and meal expenses (if the recipient lives more than 100 miles from the facility) up to $10,000 per transplant for the recipient and one companion (two companions if the recipient is a minor) and your organ donor, if applicable. For more information, contact us at 1-800-410-7778 before scheduling your pre-transplant evaluation.	National Transplant Program: 10% of the Plan's allowance and all charges over $1,000,000. PPO: 15% of the Plan's allowance and all charges over $200,000. Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $100,000. Note: National Transplant Program participants – the Plan may approve reasonable travel, lodging and meal expenses (if the recipient lives more than 100 miles from the facility) up to $10,000 per transplant for the recipient and one companion (two companions if the recipient is a minor) and your organ donor, if applicable. For more information, contact us at 1-800-410-7778 before scheduling your pre-transplant evaluation.

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You Pay — Standard Option**	**You Pay — High Option**
National Transplant Program – The Plan participates in the **First Health**® National Transplant Program. Because transplantation is a highly specialized area, not all PPO hospitals are part of the National Transplant Program. You or your physician must call us at 1-800-410-7778 as soon as the possibility of a transplant is discussed. When you call, you will be given information about the program, including a list of participating facilities. To receive the highest level of benefits, you must choose one facility within the special network of transplant facilities. Transplant-related services must be received at the facility you choose in order to be covered under the National Transplant Program benefit. All transplant admissions must be precertified by calling us at our toll-free number.	National Transplant Program: 10% of the Plan's allowance and all charges over $1,000,000. PPO: 15% of the Plan's allowance and all charges over $200,000. Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $100,000.	National Transplant Program: 10% of the Plan's allowance and all charges over $1,000,000. PPO: 15% of the Plan's allowance and all charges over $200,000. Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount. All charges over $100,000.
Note: Limited Benefits – The maximum benefit for any organ/tissue transplant(s) is $1,000,000 per occurrence for The National Transplant Program, $200,000 per occurrence for PPO services or $100,000 per occurrence for non-PPO services, which includes the following transplant-related expenses: pre-transplant evaluation, hospital care, professional fees and donor expenses. Expenses related to complications arising during the transplant admission are considered part of the same occurrence. Outpatient prescription drugs and approved travel expenses related to the transplant are not subject to the transplant maximums.		
Not covered: • *Expenses for services or supplies specifically excluded by the plan, unless part of a treatment plan approved through the National Transplant Program.* • *Donor screening tests and donor search expenses except those performed on the actual donor or those not approved through the National Transplant Program.* • *Travel, lodging and meal expenses not approved by the Plan.* • *Services and supplies for or related to transplants not listed as covered. Related services or supplies include administration of chemotherapy when supported by transplant procedures.*	*All Charges*	*All Charges*

Anesthesia	You Pay — Standard Option	You Pay — High Option
Professional services for the administration of anesthesia in hospital and out of hospital.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". If applicable, the calendar year deductible is $300 per person ($900 per family) for Standard Option and $250 per person ($750 per family) for High Option.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or 5(b).
- Note: When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists may not all be preferred providers.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY**. Please refer to the precertification information shown in Section 3.

IMPORTANT

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

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Pathology tests • Diagnostic laboratory and X-rays • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Autologous blood donations • Internal prosthesis Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its anesthetists' services, we pay Hospital benefits and when the anesthetist bills directly we pay under Section 5(b) Surgical and Anesthesia Services benefits. Note: The maximum benefit for any organ/tissue transplant, as described on page 38 is $1,000,000 per occurrence for transplants performed at a National Transplant Program facility, $200,000 per occurrence for transplants performed at a PPO facility, or $100,000 per occurrence for transplants performed at a non-PPO facility. Benefits issued for charges related to complications arising during the transplant confinement (same admission) are subject to the applicable transplant maximum. Included in the transplant maximums are hospital, surgical, and other medical expenses. Outpatient prescription drugs and approved travel expenses related to the transplant are not subject to the transplant maximums. Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support is covered only for the specific diagnoses listed on page 38. Note: The Plan pays Inpatient Hospital Benefits as shown above in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient.	See page 41	See page 41

Inpatient hospital – continued on next page

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

Outpatient hospital, freestanding ambulatory surgical center, or clinic	You Pay — Standard Option	You Pay — High Option
Services and supplies provided on the day of an outpatient surgical procedure, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays and pathology services • Blood and blood plasma, if not donated or replaced, and other biologicals, including the administration • Pre-surgical testing (performed on the day of surgery) • Dressings, casts, and sterile tray services • Medical supplies, including anesthesia and oxygen • Anesthetics and anesthesia services Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. Note: If the stay is greater than 23 hours, you need to precertify the admission. Note: For services billed by the surgeon and the anesthetist, see Section 5(b).	PPO: Nothing after the calendar year deductible Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: Nothing after the calendar year deductible Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Services and supplies not related to an outpatient surgical procedure (except pre-surgical testing not performed on the day of surgery) such as: • Treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays and pathology services • Blood and blood plasma, if not donated or replaced, and other biologicals, including the administration • Dressings, casts, and sterile tray services • Medical supplies, including anesthesia and oxygen • Anesthetics and anesthesia services Note: If the stay is greater than 23 hours, you need to precertify the admission.	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Outpatient hospital, freestanding ambulatory surgical center, or clinic *(continued)*	**You Pay — Standard Option**	**You Pay — High Option**
Not covered: *Surgical facility charges billed by entities that are not accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAfHO) or the Accreditation Association for Ambulatory HealthCare (AAAHC), or which do not have Medicare certification as an ASC facility.*	*All charges*	*All charges*
Extended care benefit/skilled nursing care facility benefit		
No benefit	*All Charges*	*All Charges*
Hospice care		
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. • We pay $5,000 per lifetime for any combination of inpatient and outpatient services. If you use a PPO provider, your out-of-pocket expenses will be reduced.	PPO: All charges after the Plan has paid $5,000 Non-PPO: All charges after the Plan has paid $5,000	PPO: All charges after the Plan has paid $5,000 Non-PPO: All charges after the Plan has paid $5,000
Not covered: • *Independent nursing, and homemaker services* • *Charges above $5,000.*	*All Charges*	*All Charges*
Ambulance		
Local professional ambulance service when medically appropriate to the first hospital where treated and from that hospital to the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition requires immediate evacuation	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 10% of the Plan's allowance (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: Non-medically necessary transport	*All Charges*	*All Charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($900 per family) for Standard Option and $250 per person ($750 per family) for High Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. See Section 4 for more information about deductibles and other cost-sharing features such as coinsurance and copayments.
- The non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is an accidental injury? An accidental injury is a bodily injury sustained through external and accidental means, such as broken bones, animal bites, poisonings and injuries to sound natural teeth. Masticating (chewing) incidents are not considered to be accidental injuries.

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

Accidental injury – continued on next page

Accidental injury *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Non-surgical physician services provided in a doctor's office for your accidental injury.	PPO: $18 copayment per office visit (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)	PPO: $15 copayment per office visit (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)
Medical emergency		
Outpatient medical or surgical services and supplies for services rendered in a hospital emergency room or urgent care center (including observation room)	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Non-surgical physician services and supplies provided in a doctor's office	PPO: $18 copayment per office visit (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)	PPO: $15 copayment per office visit (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)
Ambulance		
Local professional ambulance service when medically appropriate to the first hospital where treated and from that hospital to the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition warrants immediate evacuation.	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 10% of the Plan's allowance Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: When used for non-emergency purposes	*All Charges*	*All Charges*

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

IMPORTANT

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary and/or clinically appropriate.
- The Mental health and substance abuse benefits calendar year deductible is $300 per person ($900 per family) for Standard Option and $250 per person ($750 per family) for High Option. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. This calendar year deductible is in addition to the calendar year deductible for medical services and the calendar year deductible for prescription drugs.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES**. See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 50.

IMPORTANT

Benefit Description	You Pay After the Calendar Year deductible …	
	Standard Option	**High Option**
Managed In-Network Benefits	**You Pay – Standard Option**	**You Pay – High Option**
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Managed In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions	Your cost sharing responsibilities are no greater than for other illnesses or conditions
• Outpatient professional services, including individual or group therapy by providers approved by the Managed In-Network vendor. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist. • Medication management	$18 copayment per office visit (No deductible)	$15 copayment per office visit (No deductible)

Managed In-Network Benefits – continued on next page

Managed In-Network Benefits *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
• Inpatient professional services	10% of the Plan's allowance	10% of the Plan's allowance
• Electroshock therapy and laboratory procedures • Diagnostic tests including psychological testing	10% of the Plan's allowance	10% of the Plan's allowance
• Services provided by a hospital or other inpatient facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$150 per admission	Nothing
Not covered: Services we have not approved	*All Charges*	*All Charges*
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.		

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

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

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

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

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

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

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 53.
- Please remember all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The deductible for prescription drugs is separate from the annual deductible for medical benefits and separate from the annual deductible for mental health and substance abuse. We added "(No deductible)" to show when the calendar year prescription drug deductible does not apply.
- The Calendar Year prescription drug deductible is $600 per person ($1,200 per family) for Standard Option. The Plan will waive all or part of the prescription deductible as described on page 53 for members who have Medicare Parts A and B as their primary coverage.
- The Calendar Year prescription drug deductible is $250 per person ($500 per family) for High Option. The Plan will waive all of the prescription deductible as described on page 53 for members who have Medicare Parts A and B as their primary coverage.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription?** A physician or other covered provider acting within the scope of their license.
- **Where you can obtain them?** You may fill the prescription at a **First Health®** Rx participating pharmacy ("network" or "network pharmacy"), a non-network pharmacy or by mail for certain drugs. We pay a higher level of benefits when you use a network pharmacy.

  Network pharmacy – Present your Plan identification card at a participating Network pharmacy to purchase prescription drugs. You must have the pharmacy file the claim electronically for you in order to receive the network pharmacy level benefit. Call 1-800-410-7778 or check the electronic directory via www.mhbp.com to locate the nearest network pharmacy.

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

  Mail order – To obtain more information about the mail order drug program, order refills, check order status and request additional mail services envelopes and claim forms, or to ask questions about eligibility, copayments or other issues, call the Plan at 1-800-410-7778 or visit our web site at www.mhbp.com.
- **We administer an open formulary.** We administer a Formulary Management Program designed to control costs for you and the Plan. The formulary includes all FDA-approved drugs that have been placed in tiers based on their clinical effectiveness, safety and cost. The tiers or categories include:

  Generic Drug Category includes primarily generic drugs;

  Preferred Drug Category includes preferred brand name drugs;

  Non-Preferred Drug Category includes non-preferred brand name drugs.

  Please note: While most generic drugs fall within the Generic category, some may not, based on the clinical effectiveness of these medications. Information about the program and a copy of the current formulary was included with your identification card. When you need a prescription, share the formulary with your provider and request a Generic or Preferred drug if possible. By choosing Generic or Preferred drugs, you may decrease your out-of-pocket expenses. While all currently FDA-approved drugs are included on the formulary list, your plan may elect to have restrictions on certain drugs, including but not limited to, quantity limits, age limits, dosage limits and prior authorization. To order a prescription drug brochure, call us at 1-800-410-7778.

- **There are dispensing limitations.** All prescriptions will be limited to a 30-day supply for retail and a 90-day supply for mail order. Also, in most cases, refills cannot be obtained until 75% of the drug has been used. Occasionally, as part of regular review, we may recommend that the use of a drug is appropriate only with limits on its quantity, total dose, duration of therapy, age, gender or specific diagnosis. Since the prescription does not usually explain the reason your provider prescribed a medication, we may implement any of these limits and/or require prior authorization to confirm the intent of the prescriber. We require prior authorization for the following drugs: growth hormones; replacement enzymes; Enbrel; Kineret; Remicade; Avita or Retin A, Gleevec™; drugs used to treat Attention Deficit Disorder and narcolepsy, Oxycontin; and Tracleer. Call us at 1-800-410-7778 if you have any questions regarding prior authorization, quantity limits, or other issues.
- **Why use generic drugs?** A generic drug is the chemical equivalent to a brand name drug, yet it costs much less. Choosing generic drugs rather than Preferred or Non-Preferred brand name drugs can reduce your out-of-pocket expenses. The U.S Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. They must contain the same active ingredients, be equivalent in strength and dosage, and meet the same standards for safety, purity and effectiveness as the original brand name product.
- **The plan conducts Drug Utilization Review (DUR).** We may perform a periodic review of prescriptions to help ensure your safety and to provide health education and support. Upon review, we may contact you or your provider(s) to discuss your current medical situation and may offer assistance in coordinating care and treatment. When you fill your prescription at a network pharmacy or through the mail order program, we and/or the pharmacist may electronically access information about prior prescriptions, checking for harmful drug interactions, drug duplication, excessive use and the frequency of refills. DUR helps protect against potentially dangerous drug interactions or inappropriate use. When appropriate, your pharmacist(s) and/or **First Health**® Rx may contact your physician(s) to discuss an alternative drug or treatment option, prescription drug compliance, and the best and most cost-effective use of services. For more information about this program, call us at 1-800-410-7778.
- **When you have to file a claim.** If you purchase prescriptions at a non-network pharmacy, mail your prescription receipts to: The Mail Handlers Benefit Plan, Prescription Drug Claims, Box 45306, Jacksonville, FL 32232-5306. Receipts must include the prescription number, name of drug, date, prescribing doctor's name, date, charge, and name and address of drugstore and NDC number (included on the bill).

Note: All drugs may not be available through the mail order program. Some of the drug classes that are not available are: narcotics, hospital solutions and certain drugs such as antipsychotic agents and AIDS therapies and other drugs for which state or federal laws or medical judgment limit the dispensing amount to less than 90 days. In addition, some injectables may not be available through mail-order services. However, these excluded drugs are covered under the retail prescription drug program. For questions about the mail-order prescription drug program or to inquire about specific drugs or medications, please call 1-800-410-7778.

This Plan has two levels of reimbursement for retail prescription drug claims. One is for prescriptions filled at a network pharmacy for claims filed electronically or for prescriptions filled at a foreign pharmacy while you are living outside the United States. The second is for prescriptions filled at a non-network pharmacy or other vendor, or when you reside in the United States and choose to submit a paper claim. It is in your best interest to have your prescription filled at a network pharmacy that files your claims electronically. If you do not file electronically and do not live overseas, your reimbursement will be reduced to 50% of the allowable charges. Remember to show your Mail Handlers Benefit Plan ID card with the **First Health**® Rx logo to receive increased benefits and the convenience of having your claims filed electronically for you.

Prescription drug benefits begin on the next page

Benefit Description	You Pay After the calendar year deductible …	
	Standard Option	High Option
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Covered medications and accessories	**You Pay – Standard Option**	**You Pay – High Option**
You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail (for certain prescription drugs): • Drugs and medicines that by Federal law of the United States require a doctor's written prescription, including chemotherapy and drugs used to treat the side effects of chemotherapy. • Disposable needles and syringes, and alcohol swabs (if purchased at a pharmacy). • Insulin and related testing material. • Hormone based contraceptives, including implants. (Implant insertions are covered under Surgical Benefits.) • Diaphragms. • Smoking deterrents. For questions about the prescription drug program, please call 1-800-410-7778.	Network pharmacies or prescriptions filled by foreign pharmacies: $8 per Generic drug/$28 per Preferred brand name drug/$40 per Non-Preferred brand name drug Non-network pharmacies/Paper claims for prescriptions filled at a network pharmacy: 50% of the Plan's allowance for the prescription Network pharmacies with Medicare: $8 per Generic drug/$28 per Preferred brand name drug/$40 per Non-Preferred brand name drug (waiver of one-half ($300) of the deductible) Mail Order: $10 per Generic drug/$40 per Preferred brand name drug/$55 per Non-Preferred brand name drug Mail Order Medicare: $10 per Generic drug/$40 per Preferred brand name drug/$55 per Non-Preferred brand name drug (No deductible)	Network pharmacies or prescriptions filled by foreign pharmacies: $7 per Generic drug/$23 per Preferred brand name drug /$35 per Non-Preferred brand name drug Non-network pharmacies/Paper claims for prescriptions filled at a network pharmacy: 50% of the Plan allowance for the prescription. Network pharmacies with Medicare: $7 per Generic drug/$23 per Preferred brand name drug/$35 per Non-Preferred brand name drug (No deductible) Mail Order: $10 per Generic drug/$30 per Preferred brand name drug/$45 per Non-Preferred brand name drug Mail Order Medicare: $10 per Generic drug/$30 per Preferred brand name drug/$45 per Non-Preferred brand name drug (No deductible)

Covered medications and accessories – continued on next page

Covered medications and accessories *(continued)*	**You Pay – Standard Option**	**You Pay – High Option**
Not covered: • *Drugs and supplies for cosmetic purposes.* • *Prescriptions written by a non-covered provider.* • *Vitamins, nutrients and food supplements, whether or not a physician's prescription is required.* • *Nonprescription drugs* or *medicines.* • *Anorexiants or weight loss medications.* • *Erectile dysfunction drugs.* • *Drugs and supplies when another insurance plan or payer provides benefits, regardless of actual payment, for these services/supplies except Medicare Part B covered diabetic supplies.* • *Any amount in excess of the cost of the generic drug when a generic is available and the physician has not specified that the pharmacist dispense the brand name drug.*	*All charges*	*All charges*

Section 5 (g). Special features

Special Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
First Health® OnCall	**First Health**® OnCall provides integrated health benefit services including a national PPO network, clinical management services, a national transplant program, a care support program with Internet visits, round-the-clock benefits support, pharmacy network and plan administration. A brief description of the specialized maternity program, care support and Internet visits is included below. If you have questions about any of the programs, your benefits or would like general health information, call us at 1-800-410-7778, 24 hours a day, 7 days a week.
– Specialized Maternity Program	The specialized maternity program is a voluntary service designed to assist you during your pregnancy by identifying high-risk pregnancies to promote positive outcomes for the mother and baby and to assist in coordinating cost-effective care. To access the program, call us at 1-800-410-7778 during your first trimester. A nurse case manager will ask questions about your general health and medical history. If appropriate, a case manager will follow your case, inform you about specialists and/or facilities when applicable, and coordinate communication among you and the health care providers involved in your care.
– **First Health**® Care Support Program	A voluntary program providing a variety of disease management services designed to help you manage a chronic condition successfully with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. Examples of conditions that can be managed through this program are: diabetes, asthma and heart failure. We use medical and/or pharmacy claims data as well as interactions with you and your physician(s) to determine if you may benefit from this program. If you have a chronic condition and would like more information, or if you have questions about your current treatment, call us at the toll-free number.
– Internet visit	If you have a chronic illness and are receiving care support services, you and your PPO network physician may be able to help manage your condition using Internet visits. This service allows you to communicate with your physician, privately and securely, via the Internet. You are the only one allowed to initiate an Internet visit. You will be able to log on to a password-protected web site and send a non-urgent message with pertinent information or questions regarding your condition to your physician. In turn, your physician will respond to your message, which may verify that your current treatment plan is working well, state what changes need to be made to your treatment plan, give answers to your questions, or recommend that you schedule an office visit. Using Internet visits does not affect your ability to seek a face-to-face consultation with your physician, and the Plan will always respect the physician-patient relationship. We limit the number of Internet visits to 24 per year. Please note: To use this service, this must be your primary plan for payment of benefits, you must have an established relationship with the treating physician for your illness and your physician must be participating in the network at the time of the Internet visit. If you have any questions or would like to register for this service, call us at 1-800-410-7778, at any time, day or night. **Note: Services provided under this benefit are not subject to the FEHB disputed claims process.**

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no deductible for High Option Dental Benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- High Option pays actual charges up to the amounts specified in the schedule of dental allowances for covered dental procedures, up to a maximum benefit of $800per person and $1,600 per family per calendar year.
- For covered dental procedures not shown, the Plan will pay, subject to the limits provided, amounts consistent with procedures which are shown.
- Dental PPO — The Plan offers access to a network of dentists who have agreed to provide services at a discounted rate. To locate a preferred dentist in your area or for information about the Plan's benefits, call 1-800-410-7778 or visit the Plan's web site www.mhbp.com.
- 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.

Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. Inpatient hospitalizations must be precertified by the Plan. See Section 5(c) for hospital benefits.

The following is a partial schedule of dental allowances.

IMPORTANT

Dental benefits

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

Dental benefits – continued on next page

Dental benefits *(continued)*

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

Dental benefits – continued on next page

Dental benefits *(continued)*

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

Dental benefits – continued on next page

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

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

What is not covered

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

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

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

- **Vision One Eyecare Program**® provides Plan enrollees and eligible family members the ability to obtain $35 eyeglass examinations and discounts of up to 60% on eyeglasses and contact lenses from Vision One providers. For more information concerning the Vision One Eyecare Program® or to locate a participating Vision One center near you, visit the Plan's web site (www.mhbp.com), or call 1-800-804-4384.
- **Laser Vision Correction Program** provides Plan enrollees and eligible family members the ability to take advantage of substantial savings (typical savings between $100 and $800 for two eyes) when using The Cole LASIK Network. This program offers hundreds of locations nationwide. For more information about the program or to locate a participating doctor, call 1-888-705-2020.
- **Miracle-Ear Hearing Program** provides Plan enrollees and eligible family members the ability to obtain free hearing tests* and examinations, free counseling, free check-up and cleaning of instruments, and a discount off of suggested retail prices of Miracle-Ear hearing aid products. Consult your Yellow Pages for a Miracle-Ear Center or Sears Hearing Aid Center, or simply call the Miracle-Ear Consumer Affairs Department at 1-800-456-6801 for the location nearest you.

  * Hearing test always free. Not a medical exam. Audiometric test to determine proper amplification needs only.

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

- **High Option Dental Supplement Plan** offers increased dental coverage to High Option enrollees and covered dependents. The Dental Supplement Plan will automatically increase benefits for covered diagnostic, preventive, and periodontal services by 60%; benefits for all other covered services will increase by 30%. Enrollees and covered dependents will also receive benefits for a second annual cleaning and exam. There is no deductible for this plan and no extra claim forms. For more information about the High Option Dental Supplement Plan, you may call 1-800-621-0839. (Not available in MN.)
- **Standard Option Dental Program** provides dental benefits for Mail Handlers Benefit Plan Standard Option enrollees and their eligible family members. Like the regular MHBP High Option dental benefits, the Standard Option Dental Program pays benefits up to a scheduled allowance for most dental procedures up to a maximum annual benefit of $800 per person or $1,600 per family. And, like the regular High Option dental benefits, you can take advantage of Preferred Provider dentists to reduce your out-of-pocket costs even further. This plan has no deductible and you are always free to see any dentist you choose. For more information on this program, please call 1-800-621-0839.
- **Group Long Term Care Program** is designed to help people cope with the potentially devastating costs associated with long term care. The Mail Handlers Group Long Term Care Program lets enrollees choose the type of care they receive and where they receive it, either in a nursing home, assisted living facility, community setting, or at home. Long Term Care benefits are typically not provided by regular group health insurance, and Medicare benefits are limited, so coverage for long term care expenses can be an important financial decision. Complete information on the Mail Handlers Group Long Term Care Program, including a full explanation of rates and benefits, can be requested by visiting the MHBP web site (www.mhbp.com) or a kit can be requested by calling 1-800-522-0100. This program is underwritten by Continental Casualty Company, a CNA company. (Not available in MD)
- **Hospital Money Plan** provides daily cash benefits for hospitalization. Cash payments of up to $100 per day are paid directly to enrollees when they or a covered family member are hospitalized for any covered sickness or accident. If confinement is for intensive care, benefits of up to $200 per day are paid. The money is paid directly to the enrollee and may be spent in any way. For additional information concerning the Hospital Money Plan, you may call 1-800-621-0839.
- **Accident Security Plan** provides a $25,000 Accidental Death Benefit, with 25% of additional death benefits payable for victims of a felonious assault, and up to 15% of additional death benefits payable for car accident victims that wear their seatbelt and have an air bag in their automobile. In addition, the program provides for $150 a week when an enrollee is totally disabled by an off-work injury. For more information about the Accident Security Plan, you may call 1-800-621-0839.
- **Short-Term Disability Income Protection** provides up to $500 or $1,000 per month to enrollees to replace lost income for a period of up to 12 or 24 months as a result of a disability due to a covered illness, injury, or complications of pregnancy. The benefit choice and period is up to the enrollee. All enrollees under the age of 60 are guaranteed acceptance in this plan as long as they actively work at least 30 hours a week and have not been hospitalized in the last six months. For more information about this program, call 1-800-621-0839.

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

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services and supplies for which there would be no charge if the covered individual had no health insurance coverage;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction or sexual inadequacy, penile prosthesis;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services and supplies furnished by household members or immediate relatives, such as spouse, parents, grandparents, children, brothers or sisters by blood, marriage or adoption;
- Services and supplies furnished or billed by a non-covered facility, except that medically necessary prescription drugs are covered;
- Services, drugs and supplies associated with care that is not covered, though they may be covered otherwise (e.g., Inpatient Hospital Benefits are not payable for non-covered cosmetic surgery);
- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copayment or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 15), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge) (see page 16), or State premium taxes however applied;
- Services, drugs and supplies for weight control or treatment of obesity, except surgery for documented morbid obesity;
- Educational, recreational or milieu therapy, whether in or out of the hospital;
- Services and supplies for cosmetic purposes, except as provided under Surgical Benefits/Reconstructive Surgery;
- Biofeedback;
- Cardiac rehabilitation;
- Eyeglasses, contact lenses and hearing aids, except as provided under Section 5(a);
- Orthotics, splints, stents and appliances used to treat temporomandibular joint dysfunction and/or sleep apnea;
- Custodial care (see definition) or domiciliary care;
- Travel, even if prescribed by a doctor, except as provided under the National Transplant Program or Ambulance Benefit;
- Handling Charges/Administrative Charges or late charges, including interest, billed by providers of care;
- Charges for medical records not requested by us; and
- Services and/or supplies not listed as covered in this brochure.

Section 7. Filing a claim for covered services

How to claim benefits

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

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

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

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

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

In addition:

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

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

  The Mail Handlers Benefit Plan
  P.O. Box 44242
  Jacksonville, FL 32231-4242

- Claims for prescription drugs and supplies that are not ordered through the mail order prescription drug program or not purchased from and electronically filed with a participating **First Health**® Rx network pharmacy must include receipts that include the NDC number (included on the bill), name of drug or supply, date, charge and name and address of the pharmacy.

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

  The Mail Handlers Benefit Plan
  Prescription Drug Claims
  P.O. Box 45306
  Jacksonville, FL 32232-5306

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

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

Records

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Direct payment to hospital or provider of care

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

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

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

When we need more information

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

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

Section 8. The disputed claims process

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

Step	Description

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

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

(b) Send your request to us at: The Mail Handlers Benefit Plan, P.O. Box 44242, Jacksonville, FL 32231-4242; and

(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

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

(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or

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

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

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

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

We will write to you with our decision.

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

You must write to OPM within:

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

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

Send OPM the following information:

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

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

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

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

The disputed claims process *(continued)*

Step	Description
5	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute. **NOTE: If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-410-7778 and we will expedite our review; or (b) We denied your initial request for care or preauthorization/prior approval, then: • If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or • You may call OPM's Health Benefits Contracts Division 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating Benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays medical expenses without regard to fault. This is called "double coverage."

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. The combined payment from both plans may be less than (but will not exceed) the entire amount billed by the provider.

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

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

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

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

We waive some costs if the Original Medicare Plan is your primary payer— We will waive some out-of-pocket costs, as follows:

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

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

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

- When Medicare Part A is primary, the Plan will waive applicable per-admission copayments and coinsurance for Inpatient Hospital Benefits and Inpatient Mental Health/Substance Abuse Benefits.
- When Medicare Part B is primary, the Plan will waive applicable deductibles, copayments and coinsurance for surgical and medical services billed by physicians, durable medical equipment, orthopedic and prosthetic appliances and ambulance services.
- When Medicare Part B is primary, the Plan will waive the calendar year deductible (but not the coinsurance) for nursing benefits and outpatient mental health/substance abuse benefits.
- When Medicare Parts A and B are primary, the Plan will waive the full deductible for prescription drugs purchased through the mail order prescription drug program for both High Option and Standard Option.
- When Medicare Parts A and B are primary, the Plan will waive the full High Option prescription drug deductible for prescriptions purchased at a retail pharmacy.
- When Medicare Parts A and B are primary, the Plan will waive $300 of the Standard Option prescription drug deductible for prescription drugs purchased at a retail pharmacy.

Note: The Plan will not waive the copayments and coinsurance for retail or mail order prescription drugs.

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

Primary Payer Chart

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

- **Medicare managed care plan**

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

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

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

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

- **Private Contract with your physician**

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

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

When other government agencies are responsible for your care

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

When others are responsible for injuries

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

Section 10. Definitions of terms we use in this brochure

Admission

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

Assignment

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

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 12.

Congenital anomaly

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Covered services

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

Custodial care

The Plan determines what services are custodial in nature. Custodial care that lasts 90 days or more is sometimes known as Long term care. For instance, the following are considered custodial services:

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services

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

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

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

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

Group health coverage

Health care coverage that a member is eligible for because of employment, by membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.

Hospice care program

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

Medical necessity

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

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

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

Morbid obesity

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

Orthopedic appliance

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

Plan allowance

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

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

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

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

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

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

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

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

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

Prosthetic appliance

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

Scooters

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

Us/We

Us and we refer to the Mail Handlers Benefit Plan.

Vested rights

An enrollee does not have a vested right to the benefits in this brochure in 2004 or later years and does not have a right to benefits available prior to 2003 unless those benefits are in this brochure.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB program

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

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

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

Types of coverage available for you and your family

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

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

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

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren). If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

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

Children's Equity Act *(continued)*

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

- **Temporary continuation of coverage (TCC)**

  If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

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

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

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557)** or visiting www.ltcfeds.com to get more information and to request an application.

Index

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

Summary of Standard Option benefits for the Mail Handlers Benefit Plan – 2003

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $300 Calendar Year medical deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page(s)
Medical services provided by physicians: • Diagnostic and treatment services provided in the office • Inpatient hospital visits • Preventive care (see specific services) • Maternity services • Treatment therapy, rehabilitative therapies, chiropractic, alternative therapies (subject to applicable calendar year maximum)	PPO: $18 copayment per office visit; $5 copayment per allergy injection; 10%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services Non-PPO: 30% of the Plan's allowance per office visit; 30%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services	18-32
Services provided by a hospital: • Inpatient • Outpatient — surgical facility — laboratory and radiology — hemodialysis, chemotherapy, radiation treatment	 PPO: $150 per admission Non-PPO: $300 per admission PPO: Nothing after the calendar year deductible Non-PPO: 30%* of the Plan's allowance PPO: 10%* of the Plan's allowance Non-PPO: 30%* of the Plan's allowance	 41-43 44 25
Emergency benefits: • Accidental injury • Medical emergency	 Regular benefits Regular benefits	 46-47 47
Mental health and substance abuse treatment Note: This benefit has a separate calendar year deductible.	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	48-50
Prescription drugs	After $600 per person ($1,200 per family) calendar year prescription deductible: Network Retail electronic: $8 per Generic drug/$28 per Preferred brand name drug/$40 per Non-Preferred brand name drug Network Retail paper: 50% of plan allowances Non-Network Retail: 50% of plan allowance Mail Order: $10 per Generic drug; $40 per Preferred brand name drug; $55 per Non-Preferred brand name drug	51-54
Dental Care	No benefit	N/A
Special features: Flexible Benefits Option; **First Health®** OnCall		55
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) There is a separate out-of-pocket maximum for Managed In-Network mental health and substance abuse treatment services that must be met for this benefit to apply. This benefit does not apply to mental health and substance abuse treatment services provided by out-of-network providers.	Nothing after your covered expenses total $4,000 per year for PPO providers/facilities. When you use a combination of PPO and non-PPO providers, your covered out-of-pocket expenses will not exceed $6,500. Some costs do not count toward this protection.	13

Summary of High Option benefits for the Mail Handlers Benefit Plan – 2003

- **Do not rely on this chart alone**. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $250 Calendar Year medical deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page(s)
Medical services provided by physicians: • Diagnostic and treatment services provided in the office • Inpatient hospital visits • Preventive care (see specific services) • Maternity services • Treatment therapy, rehabilitative therapies, chiropractic, alternative therapies (subject to applicable calendar year maximum)	PPO: $15 copayment per office visit; $5 copayment per allergy injection; 10%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services Non-PPO: 30% of the Plan's allowance per office visit; 30%* of the Plan's allowance for diagnostic X-rays, laboratory services and other professional services	18-32
Services provided by a hospital: • Inpatient	PPO: Nothing Non-PPO: $250 per admission	41-43
• Outpatient — surgical facility	PPO: Nothing after the calendar year deductible Non-PPO: 30%* of the Plan's allowance	44
— laboratory and radiology — hemodialysis, chemotherapy, radiation treatment	PPO: 10%* of the Plan's allowance Non-PPO: 30%* of the Plan's allowance	25
Emergency benefits: • Accidental injury • Medical emergency	 Regular benefits Regular benefits	 46-47 47
Mental health and substance abuse treatment Note: This benefit has a separate calendar year deductible.	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	48-50
Prescription drugs	After $250 per person ($500 per family) calendar year prescription deductible: Network Retail electronic: $7 per Generic drug/$23 per Preferred brand name drug /$35 per Non-Preferred brand-name drug Network Retail paper: 50% of plan allowance Non-Network Retail: 50% of plan allowance Mail Order:$10 per Generic drug; $30 per Preferred brand name drug; $45 per Non-Preferred brand name drug	51-54
Dental Care	All charges above amount stated in dental schedule	56-59
Special features: Flexible Benefits Option; **First Health®** OnCall		55
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) There is a separate out-of-pocket maximum for Managed In-Network mental health and substance abuse treatment services that must be met for this benefit to apply. This benefit does not apply to mental health and substance abuse treatment services provided by out-of-network providers.	Nothing after your covered expenses total $3,000 per year for PPO providers/facilities. When you use a combination of PPO and non-PPO providers, your covered out-of-pocket expenses will not exceed $6,000. Some costs do not count toward this protection.	13

2003 Rate Information for the Mail Handlers Benefit Plan

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

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

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

		Non-Postal Premium				***Postal Premium***	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	451	$109.30	$64.29	$236.82	$139.29	$129.03	$44.56
High Option Self and Family	452	$249.62	$116.54	$540.84	$252.51	$294.70	$71.46
Standard Option Self Only	454	$84.26	$28.09	$182.57	$60.86	$99.71	$12.64
Standard Option Self and Family	455	$182.92	$60.97	$396.32	$132.11	$216.45	$27.44