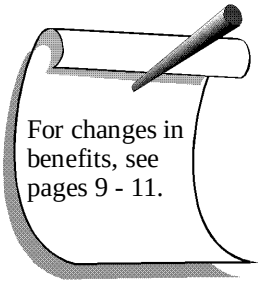
Mail Handlers Benefit Plan

www.mhbp.com – 1.800.410.7778

2011

A fee for service plan (Standard Option and Value Plan) and a high deductible health plan (Consumer Option) with a preferred provider organization

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



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, AFL-CIO, a division of LIUNA.

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, AFL-CIO, a division of LIUNA.

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

Enrollment codes for this Plan:

414 Value Plan - Self Only
415 Value Plan - Self and Family

454 Standard Option - Self Only
455 Standard Option - Self and Family

481 Consumer Option - Self Only
482 Consumer Option - Self and Family

URAC ACCREDITED HEALTH UTILIZATION MANAGEMENT COVENTRY HEALTH CARE NATIONAL ACCOUNTS

URAC ACCREDITED DISEASE MANAGEMENT COVENTRY HEALTH CARE NATIONAL ACCOUNTS

Other URAC Accreditations:

- Caremark, Inc.
  - Pharmacy Benefit Management
  - Drug Therapy Management
- Caremark Rx, LLC
  - Health Web Site
  - Specialty Pharmacy
  - Mail Service Pharmacy
- United Behavioral Health, Houston Care Advocacy
  - Health Utilization Management

See the 2011 Guide for more information on accreditation.

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Center for Retirement and Insurance Services
http://www.opm.gov/insure

RI 71-007

Important Notice from the Mail Handlers Benefit Plan about our Prescription Drug Coverage and Medicare

OPM has determined that the Mail Handlers Benefit Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all Plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and we will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your premium will go up at least 1% per month for each month you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may also have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048).

Mail Handlers Benefit Plan Notice of Privacy Practices

We protect the privacy of your protected health information as described in our current Mail Handlers Benefit Plan Notice of Privacy Practices. You can obtain a copy of our Notice by calling us at 1-800-410-7778 or by visiting our Web site: www.mhbp.com.

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Introduction

This brochure describes the benefits of the Mail Handlers Benefit Plan. The National Postal Mail Handlers Union, AFL-CIO, a division of LIUNA, has entered into a contract (CS1146) with the United States Office of Personnel Management 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 8402
London, KY 40742

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, 2011, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2011, and changes are summarized on pages 9-11. 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. For instance, "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 United States 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 U.S. Office of Personnel Management, Insurance Operations, Program Planning & Evaluation, 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 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 that you can do to prevent fraud:

- Do not give your Plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits 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) statements that you receive from us.
- Please review your claims history periodically for accuracy to ensure services are not being billed to your accounts that were never rendered.
- 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.

Stop Health Care Fraud *(continued)*

- 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 ¾ THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- 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 age 26 or over (unless he/she was disabled and incapable of self support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- 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 if you are no longer enrolled in the Plan.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.

- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

  "Exactly what will you be doing?"

  "About how long will it take?"

  "What will happen after surgery?"

  "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Patient Safety Links

– www.ahrq.gov/consumer. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

– www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

– www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

– www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

– www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

– www.quic.gov/report/toc.htm. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use preferred providers. This new policy will help protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that will encourage hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

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 give you a choice of enrollment in Standard Option, Value Plan or Consumer Option.

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.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Questions regarding what protections apply may be directed to us at: Mail Handlers Benefit Plan, P.O. Box 8402, London, KY 40742. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of all Mail Handlers Benefit Plan Options

Preferred Provider Organization (PPO)

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are "preferred providers". 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 at 1-800-410-7778 for the names of PPO providers or to request a PPO directory. You can also go to our Web site at www.mhbp.com. 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. If your doctor is not currently participating in the provider network, you can nominate him or her to join. Physician nomination forms are available on our Web site, or call us and we'll have a form sent to you. You cannot change health plans outside of Open Season because of changes to the provider network.

The Plan uses the Coventry Health Care National Network as its PPO network in all states except Ohio and New Jersey. In Ohio, the network is administered by Medical Mutual of Ohio. In New Jersey, the network is administered by QualCare. Services from providers outside the continental United States, Alaska and Hawaii will be considered at the PPO benefit levels. 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 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. The nature of the services (such as urgent or emergency situations) does not affect whether benefits are paid as PPO or Non-PPO. However, we will provide the PPO level of benefits for services you receive from Non-PPO anesthesiologists (including Certified Registered Nurse Anesthetists (CRNA)), radiologists, pathologists, co-surgeons and emergency room physicians when inpatient services are provided in a PPO hospital and when outpatient surgical and emergency treatment services are provided at a PPO facility. You will still be responsible for the difference between our allowance and the billed amount.

Managed In-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).

Other Participating Providers

This Plan offers you access to certain Non-PPO health care providers that have agreed to discount their charges. These providers are available to you through MultiPlan and Three Rivers Provider Network (TRPN). Covered services at these participating providers are considered at the negotiated rate subject to applicable deductibles, copayments and coinsurance. Since these participating providers are not PPO providers, Non-PPO benefit levels will apply. Contact us at 1-800-410-7778 for more information about participating providers.

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 for covered services and supplies.

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*, Section 10, for further details).

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

We apply the National Correct Coding Initiative (NCCI) edits published by the Centers for Medicare and Medicaid Services (CMS) in reviewing billed services and making Plan benefit payments for them.

General features of our Consumer Option

The Consumer Option is a High Deductible Health Plan (HDHP) and has a higher annual deductible and out-of-pocket maximum limit than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

PPO Preventive care services are paid as first-dollar coverage. You do not have to meet the annual deductible before you get benefits.

Annual deductible

The annual deductible must be met before Plan benefits are paid for services other than PPO Preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term care coverage), not enrolled in Medicare, not have received VA benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance or any other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse and your dependents, even if they are not covered by an HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA, up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services from PPO providers, including deductibles, copayments and coinsurance, cannot exceed $5,000 for a Self Only enrollment, or $10,000 for a Self and Family enrollment. For covered services from Non-PPO providers your annual out-of-pocket expenses cannot exceed $7,500 for a Self Only enrollment or $15,000 for a Self and Family enrollment.

Health Education resources and management tools

Section 5(i) describes the health education resources and account management tools available to help you manage your health care and your health care dollars.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB 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 8402, London, KY 40742. You may also visit our Web site at www.mhbp.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Section 2. How we change for 2011

Do not rely only on these change descriptions; this Section 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

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a Self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized the Organ and tissue transplant benefit information to clarify coverage.
- We have reorganized Mental health and substance abuse benefits to clarify coverage.
- The State of Oklahoma was added to the list of Medically Underserved Areas.

Changes to this Plan

- We added a preauthorization requirement for specific radiology/imaging services: CT/CAT scan, CTA, MRI, MRA, NC and PET scan. Previously, preauthorization was not required for these services. See page 17.
- We added coverage for one routine human papillomavirus (HPV) screening per member per calendar year. Previously, routine HPV testing was not covered.
- We changed the benefit limit for rehabilitative, chiropractic and alternative treatment therapies combined from a benefit maximum of $2,500 per calendar year to 26 visits per person per calendar year.
- We changed the benefit limit under Durable medical equipment (DME) for augmentative and alternative communication (AAC) devices from $1,000 per calendar year to $500 per device.
- We increased coverage for smoking cessation programs to 100% for up to two quit attempts per member per calendar year, including up to four counseling sessions per quit attempt and necessary medications. Previously, the Plan paid up to $100 per member per lifetime for smoking cessation. See *Educational classes and programs*, Section 5(a).
- We added an optional maintenance drug management program that allows members to get up to 90-day refills at a CVS retail pharmacy for the same cost-sharing as mail order. Under the program, members may choose to get the initial prescription (up to a 30-day supply) and two refills at a network retail pharmacy or a non-network retail pharmacy, or through our mail order drug program in up to a 90-day supply. After the second refill at a retail pharmacy, additional refills must be obtained either from a CVS retail pharmacy or through our mail order drug program. Members may choose **not** to participate in this program by calling CVS Caremark at 1-866-623-1441. Previously, we had no maintenance drug management program.
- We added a program to encourage members to switch from certain non-generic drugs to a generic equivalent. Qualifying members can receive up to a 90-day supply of the generic drug at no cost. The generic replacement drug must be obtained at a network retail pharmacy or through our mail order drug program. To find out if you qualify for this program, call CVS Caremark at 1-866-623-1441. Previously, this program was not available.
- We changed how the Plan's allowance for Non-PPO dialysis services is determined. It is now based on the Medicare allowance. See page 134.

Changes to our Standard Option Only

- Your share of the non-Postal Standard Option Self Only premium will increase. For Standard Option Self and Family your share will increase.
- We changed the calendar year deductible to a single amount for medical services and mental health and substance abuse services combined. The deductible is now $400 per person, limited to $800 per family, for services received from PPO/In-Network providers, and $600 per person, limited to $1,500 per family, for services received from PPO/In-Network and Non-PPO/Out-of-Network providers combined.
- We changed the benefit structure and catastrophic protection limits on out-of-pocket expenses for coinsurance. We now have a single catastrophic protection benefit for medical services and mental health and substance abuse services, combined. The new catastrophic protection limits are $6,000 per calendar year for services of PPO/In-Network providers and $10,000 for services of PPO/In-Network and Non-PPO/Out-of-Network providers combined. Previously, the catastrophic protection benefit for medical services was separate from the catastrophic protection benefit for mental health and substance abuse services. The limits for each were $4,500 per calendar year for medical services of PPO/In-Network providers and $9,000 for medical services of PPO/In-Network and Non-PPO/Out-of-Network providers combined.
- We added a new benefit level for outpatient doctor's office visits to a PPO specialist. The PPO copayment for outpatient visits to a specialist is $40 per visit for all members. Previously, the PPO copayment was $20 per visits for adults and $10 per visit for dependent children under age 22.

Changes to our Standard Option Only (continued)

- We increased PPO benefits for adult annual routine physical exams. Benefits are now provided at 100% for one routine physical exam per adult member per calendar year. Previously, a $10 copayment was required.
- We increased PPO benefits for adult routine immunizations. Benefits are now provided at 100% for covered routine immunizations. Previously, a $10 copayment per visit was required.
- We increased PPO benefits for office visits related to adult routine screenings. Benefits are now provided at 100%. Previously, a $20 copayment per visit was required.
- We changed the Non-PPO benefit structure for well-child office visits to 30% of the Plan's allowance and any difference between our allowance and the billed amount, subject to the calendar year deductible. Previously, benefits were provided at 100% up to a maximum of $75 per child per calendar year, not subject to the calendar year deductible.
- We changed the benefit limit for Home health services from a benefit maximum of $1,500 per calendar year to 6 visits per person per calendar year.
- We increased the copayment for chiropractic care to $20 per visit. Previously, the copayment was $15 per visit.
- We increased the PPO copayment for visits to a hospital emergency room to $200 per occurrence. If the visit results in inpatient admission to the hospital, the copayment is waived. For emergency room visits that are related to an accidental injury, the calendar year deductible does not apply. Previously, the copayment was $150 per occurrence.
- We changed the Non-PPO benefit structure for emergency room visits to a $200 copayment per occurrence and any difference between the Plan's allowance and the billed amount. The calendar year deductible does not apply for visits related to accidental injuries, but does apply for visits related to medical emergencies. The copayment is waived for both medical emergencies and accidental injuries if the visit results in an inpatient admission. Previously, members were responsible for Non-PPO cost-sharing of 30% of the plan's allowance and any difference between the Plan's allowance and the billed amount.
- We changed the benefit structure for Preferred brand and Non-Preferred brand name prescription drugs obtained from a network retail pharmacy. The member responsibility is 30% of the Plan's allowance, limited to $200 per prescription, for Preferred brand name drugs, and 50% of the Plan's allowance, limited to $200 per prescription, for Non-Preferred brand name drugs. Previously, the member was responsible for copayments of $40 per prescription for Preferred brand name drugs and $60 per prescription for Non-Preferred brand name drugs.
- We increased the copayment amounts for Preferred brand and Non-Preferred brand name prescription drugs obtained through our mail order drug program. The copayments are $80 per prescription for Preferred brand name drugs and $120 per prescription for Non-Preferred brand name drugs. Previously, the copayments were $65 per prescription for Preferred brand name drugs and $90 per prescription for Non-Preferred brand name drugs
- We increased the copayment for a 30-day supply of specialty drugs obtained from a network pharmacy to $150 per prescription and for a 90-day supply specialty drugs obtained through our mail order drug program to $400 per prescription. Previously the copayments were $100 per prescription for a 30-day supply of specialty drugs obtained from a network pharmacy and $300 per prescription for a 90-day supply of specialty drugs obtained through our mail order drug program.
- We increased the catastrophic protection limit on out-of-pocket expenses for specialty drugs obtained from a network retail pharmacy or through our mail order drug program to $5,000 per person per calendar year. Previously, the catastrophic protection limit on out-of-pocket expenses for specialty drugs was $4,000 per person per calendar year.
- We added a voluntary pilot program for Standard Option members who are eligible for Medicare. Our pilot program is designed to help members who are enrolled in Medicare Part A to also enroll in Medicare Part B by helping to pay for some or all of the Medicare Part B premium when you enroll in the program. You may also enroll in this program if you already have Medicare Parts A and B as your primary coverage. The Plan will contribute an amount equal to the regular Medicare Part B monthly premium for each month you participate. See page 127 for more information.

Changes to our Value Plan Only

- Your share of the non-Postal Value Plan Self Only premium will increase. For Value Plan Self and Family your share will increase.
- We changed the calendar year deductible to a single amount for medical services and mental health and substance abuse services combined. The deductible is now $600 per person, limited to $1,200 per family, for services received from PPO/In-Network providers, and $900 per person, limited to $1,800 per family, for services received from PPO/In-Network and Non-PPO/Out-of-Network providers combined.
- We changed the benefit structure and catastrophic protection limits on out-of-pocket expenses for coinsurance. We now have a single catastrophic protection benefit for medical services and mental health and substance abuse services, combined. The new catastrophic protection limits are $7,000 per calendar year for services of PPO/In-Network providers and $10,000 for services of PPO/In-Network and Non-PPO/Out-of-Network providers combined. Previously, the catastrophic protection benefit for medical services was separate from the catastrophic protection benefit for mental health and substance abuse services. The limits for each were $4,000 per calendar year for medical services of PPO/In-Network providers and $6,000 for medical services of PPO/In-Network and Non-PPO/Out-of-Network providers combined.
- We added a new benefit level for outpatient doctor's office visits to a PPO specialist. The PPO copayment for outpatient visits to a specialist is $50 per visit for all members, after the calendar year deductible. Previously, the member was responsible for 20% of the Plan's allowance, after the calendar year deductible.
- We changed the benefit limit for Home health services from a benefit maximum of $900 per calendar year to 4 visits per person per calendar year.
- We increased the PPO copayment for outpatient surgical facility services to $300 per occurrence. Previously, the PPO copayment was $200 per occurrence.
- We increased the benefit level for visits to a Non-PPO emergency room. Members are now responsible for 20% of the Plan's allowance and any difference between the Plan's allowance and the billed amount. Previously, the member was responsible for 40% of the Plan's allowance and any difference between the Plan's allowance and the billed amount. The calendar year deductible continues to apply.
- We changed the benefit structure for Managed In-Network outpatient professional services related to mental health and substance abuse conditions. Members now have a $30 copayment per visit, not subject to the calendar year deductible. Previously, the member was responsible for 20% of the Plan's allowance, after the calendar year deductible.
- We increased the In-Network benefit level for outpatient testing services related to mental health and substance abuse conditions to 100% of the Plan's allowance, not subject to the calendar year deductible. Previously, the member was responsible for 20% of the Plan's allowance, after the calendar year deductible.
- We increased the catastrophic protection limit on out-of-pocket expenses for prescription drugs obtained from a network retail pharmacy or through our mail order drug program to $7,000 per person per calendar year. Previously, the catastrophic protection limit on out-of-pocket expenses for prescription drugs was $6,000 per person per calendar year.

Changes to our Consumer Option Only

- Your share of the non-Postal Consumer Option Self Only premium will increase. For Consumer Option Self and Family your share will increase.
- We changed the administrator and custodian for your HSA to HealthEquity.
- Beginning January 1, 2011, currently eligible over-the-counter (OTC) products that are medicines or drugs will not be eligible for reimbursement from your Health Savings Account (HSA) or your Health Reimbursement Arrangement (HRA) – unless – you have a prescription for that item written by your physician. The only exception is insulin - you will not need a prescription from January 1, 2011 forward. Other currently eligible OTC items that are not medicines or drugs will not require a prescription.
- The penalty for withdrawals from an HSA for non-medical expenses will increase from 10% to 20% after January 1, 2011.
- We changed the benefit limit for Home health services from a benefit maximum of $900 per calendar year to 3 visits per person per calendar year.
- We changed the Non-PPO benefit structure for emergency room visits to $50 copayment per occurrence and any difference between the Plan's allowance and the billed amount, subject to the calendar year deductible. The copayment is waived if visit results in an inpatient admission. Previously, members were responsible for Non-PPO cost-sharing of 40% of the plan's allowance and any difference between the Plan's allowance and the billed amount, subject to the calendar year deductible.
- We changed the administrator for mental health and substance abuse In-Network benefits to United Behavioral Health. Members should continue to call the Plan to be referred to an In-Network provider and to get approval for a treatment plan. Previously, In-Network benefits were administered by the Plan.

Clarifications

- We clarified that eligible out-of-pocket expenses accumulate to the calendar year deductible in the order in which claims are received for processing, which may be different than the order in which services were actually rendered.
- We clarified that charges for venipuncture are not covered when billed as a separate procedure along with charges for the related lab test. See Section 5(a).
- We clarified that donor testing for organ/tissue transplants is covered for up to four (4) candidate donors per transplant occurrence. See Section 5(b).
- We clarified the conditions under which repair of sound natural teeth due to an accidental injury are covered. See Section 5(g).
- We clarified that removal of impacted teeth are covered under Oral and maxillofacial surgery benefits, Section 5(b).
- We clarified that the Plan's benefit payment, when providing benefits as the member's secondary insurance carrier, will not exceed the member's actual responsibility, as determined by the primary carrier.

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 electronic enrollment system (such as 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 8402, London, KY 40742. 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 or who bills for the services. If you use PPO 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 (D.C.)
- 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
- a respiratory therapist
- an acupuncturist
- a physician's assistant
- a nurse midwife
- a nurse practitioner/clinical specialist
- a nursing school-administered clinic
- a certified registered nurse anesthetist (C.R.N.A)
- a Christian Science practitioner listed in the Christian Science Journal
- a Christian Science nurse listed in the Christian Science Journal

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved". For 2011, the states are: Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Carolina, South Dakota, and Wyoming.

- **Covered facilities**

Covered facilities include:

- **Freestanding ambulatory facility**. A facility that meets the following criteria:
  a) has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis;
  b) provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility;
  c) 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 Health Care (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 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 or 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 or sub-acute 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.
- **Christian Science nursing facility**. A facility which is approved by the Commission for the Accreditation of Christian Science Nursing Organizations/Facilities, Inc.
- **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.

We use InterQual criteria in making determinations regarding hospital stay precertification and extended stay reviews, observation stay reviews, and reviews of services that require precertification or preauthorization. These determinations can affect what we pay on a claim.

- **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 reasons other than for 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 your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service department immediately at 1-800-410-7778. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

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 your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay inpatient hospital benefits.

Any stay greater than 23 hours that results in a hospital admission must be precertified.

How to precertify an admission

You, your representative, your doctor, or your hospital must call us at 1-800-410-7778 at least two working days before admission.

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

Provide the following information:

- Enrollee's name and Plan identification number;
- Patient's name, birth date, and phone number;
- Reason for hospitalization, proposed treatment, or surgery;
- Name 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/or hospital the number of approved days of confinement for the care of the patient's condition. 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 needs to be extended:

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor or the hospital must contact us for precertification of the additional days.

What happens when you do not follow the precertification rules

If no one contacts us, we will decide whether the hospital stay was medically necessary.

- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will pay 70% (Standard Option) or 60% (Value Plan and Consumer Option) 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% (Standard Option) or 60% (Value Plan and Consumer Option) for covered medical services and supplies 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% (Standard Option) or 60% (Value Plan and Consumer Option) 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 payor for the hospital stay.
- Medicare Part A is the primary payor 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 payor and you **do** need precertification.
- Your stay is less than 23 hours.

- **Other services**

Some services require precertification or preauthorization before we will consider them for benefits.

- We require preauthorization for the following outpatient radiology/imaging services. See Section 5(a):
  - CT/CAT scan – Computed Tomography/Computerized Axial Tomography
  - CTA – Computed Tomography Angiography
  - MRI – Magnetic Resonance Imaging
  - MRA – Magnetic Resonance Angiography
  - NC – Nuclear Cardiac Imaging
  - PET scan – Positron Emission Tomography
- We require preauthorization for genetic testing. See Section 5(a).
- We require preauthorization for chelation therapy. See Section 5(a).
- We require preauthorization for hyperbaric oxygen therapy. See Section 5(a).
- We require preauthorization for audible prescription reading devices. See Section 5(a).
- We require preauthorization for spinal surgery. See Section 5(b).
- We require preauthorization for surgical treatment of morbid obesity (bariatric surgery). See Section 5(b).
- We require preauthorization of transplants and transplant-related services, except corneal transplants. 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).
- We require preauthorization for Vagus nerve stimulation therapy. See Section 5(e).
- We require preauthorization for outpatient intensive therapy, partial hospitalization and electroshock/electroconvulsive therapy. See *Mental health and substance abuse*, Section 5(e).
- We require preauthorization of certain classes of drugs. See Section 5(f).
- We require precertification when you have Medicare Part B only as your primary payor for an outpatient hospitalization that exceeds 23 hours and results in hospital admission.

You should call us at 1-800-410-7778 before scheduling any of the following outpatient procedures or services:

- Dialysis
- IV/infusion therapy
- Respiratory therapy
- Inhalation therapy
- Orthopedic and prosthetic devices
- Durable medical equipment
- Diabetic education
- Smoking cessation

We can help you understand your benefits and locate a PPO provider:

Section 4. Your costs for covered services

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

Copayment

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

Example: When you have Standard Option and see your PPO physician you pay a copayment of $20 per visit for adult members or $10 per visit for dependent children under age 22.

Note: If the billed amount or the Plan allowance that providers we contract with have agreed to accept as payment in full is less than your copayment, you pay the lower amount.

Cost-sharing

Cost-sharing is a general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible. Covered expenses are applied to the deductible in the order in which claims are received for processing, which may be different than the order in which services were actually rendered.

Whether or not you use PPO providers, your deductible will not exceed the applicable Non-PPO amounts.

Standard Option and Value Plan

- The Standard Option calendar year deductible for covered services and supplies is $400 per person, limited to $800 per family, for services received from PPO/In-Network providers, and $600 per person, limited to $1,500 per family, for services received from Non-PPO/Out-of-Network providers.
- The Value Plan calendar year deductible for covered services and supplies is $600 per person, limited to $1,200 per family, for services received from PPO/In-Network providers, and $900 per person, limited to $1,800 per family, for services received from Non-PPO/Out-of-Network providers.
- Under a family enrollment, the calendar year deductible is satisfied for all family members when the combined covered expenses applied to the deductible for all family members reach the respective per family limit.

Consumer Option

- The Consumer Option calendar year deductible for covered services and supplies is $2,000 for a Self Only enrollment and $4,000 for a Self and Family enrollment.

If the billed amount (or the Plan allowance that PPO/In-Network providers have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has agreed to accept $80, and you have not paid any amount toward your calendar year deductible, you must pay $80. We will apply $80 toward your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible has been satisfied.

Note: If you change plans or plan options during Open Season and the effective date of your new plan or plan option is after January 1 of the next year, you do not have to start a new deductible under your old plan or plan option between January 1 and the effective date of your new plan or plan option. 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.

If you change plans during the year, you must begin a new deductible under your new plan.

Coinsurance

Standard Option and Value Plan

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 under Standard Option and 40% of our allowance under Value Plan for Non-PPO office visits.

Consumer Option

Coinsurance is the percentage of our allowance that you must pay under Traditional Health Coverage. Coinsurance does not begin until you meet your deductible.

> Example: You pay 40% of our allowance for Non-PPO office visits.

If your provider routinely waives your cost

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 (Standard Option), the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

To help keep your coinsurance out-of-pocket costs to a minimum, we encourage you to call us at 1-800-410-7778 or visit our Web site at www.mhbp.com for assistance locating PPO providers whenever possible.

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 1-800-410-7778.

Differences between our allowance and the bill

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

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

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is a Standard Option 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 $20 of our $100 allowance for an adult office visit. Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his/her bill.
- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a Non-PPO provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and charges on the bill. Here is a Standard Option 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, the physician can bill you for the $50 difference between our allowance and his/her bill. For details on how we determine the Plan allowance, please see Section 10.
- **Participating providers** agree to limit what they can collect from you. You will still have to pay your deductible and coinsurance. These providers agree to write off the difference between billed charges and the discount amount.

Differences between our allowance and the bill *(continued)*

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 in a non-fully developed market area. 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 Standard Option if you have met your calendar year deductible.

EXAMPLE	PPO physician		Non-PPO physician	
Physician's charge		$150		$150
Our allowance	We set it at:	$100	We set it at:	$100
We pay		$80	70% of our allowance:	$70
You owe:	Copayment:	$20	30% of our allowance:	$30
+ Difference up to charge?	No:	$0	Yes:	$50
TOTAL YOU PAY		$20		$80

If you receive services in a fully developed PPO area and use a Non-PPO physician, your out-of-pocket expenses may be greater. See *Plan Allowance*, Section 10 for more details.

Consumer Option:

- **PPO providers** agree to accept our Plan allowance so if you use a PPO Provider, you never have to worry about paying the difference between the Plan's allowance and the billed amount for covered services.
- **Non-PPO Providers**: If you use a Non-PPO provider, you will have to pay the difference between the Plan allowance and the billed amount. If you have an HSA, you can choose to use funds from your HSA to pay these amounts, or you can pay them out-of-pocket. If you have an HRA, we will withdraw the amount from your HRA if funds are available. After you have exhausted your HSA or HRA, you will be responsible for paying your remaining deductible and also copayments and coinsurance under the Traditional Health Coverage.

Note: We encourage you to use PPO providers because it will make the amounts in your HSA or HRA last longer.

Your catastrophic protection out-of-pocket maximum for coinsurance

Standard Option and Value Plan:

For those services with coinsurance, we pay 100% of the Plan's allowance for the remainder of the calendar year after your coinsurance expenses total these amounts:

- $6,000 for services of PPO/In-Network providers/facilities under Standard Option
- $10,000 for services of PPO/In-Network and Non-PPO/Out-of-Network providers/facilities, combined, under Standard Option
- $7,000 for services of PPO/In-network providers/facilities under Value Plan
- $10,000 for services of PPO/In-Network and Non-PPO/Out-of-Network providers/facilities, combined, under Value Plan

The following cannot be included in the accumulation of out-of-pocket expenses. Health care providers can bill you, and you are responsible to pay them even after your expenses exceed the limits described above:

- Deductibles
- Copayments
- Expenses in excess of the Plan allowance or maximum benefit limitations
- Expenses for non-covered services and supplies
- Expenses incurred under prescription drug benefits, except for Standard Option (only) Specialty drugs and Value Plan (only) prescription drugs, described below
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 15-17)
- Coinsurance for skilled nursing care
- Coinsurance for alternative and rehabilitative therapies
- Coinsurance for chiropractic care

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

Standard Option (only) prescription drugs:

- $5,000 per person per calendar year for Specialty drugs obtained through a Network retail pharmacy or our mail order drug program

Value Plan (only) prescription drugs:

- $7,000 per person per calendar year for prescription drugs obtained through a Network retail pharmacy or our mail order drug program

Consumer Option:

PPO benefit: Your catastrophic protection out-of-pocket maximum is $5,000 for a Self Only enrollment ($10,000 Self and Family) when you use PPO providers/facilities and pharmacies. Only eligible expenses for network providers count toward this limit.

Out of pocket expenses for purposes of this benefit are:

- Your annual deductible
- The copayments you pay for covered in-network services under the Traditional Health Coverage

The following cannot be included in the accumulation of out-of-pocket expenses. Health care providers can bill you, and you are responsible to pay them even after your expenses exceed the limits described above:

- Expenses in excess of the Plan's allowance or maximum benefit limitations
- Expenses for non-covered services and supplies
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 15-17)

Non-PPO benefit: Your catastrophic protection out-of-pocket maximum is $7,500 for a Self Only enrollment ($15,000 Self and Family) when you use Non-PPO providers/facilities. Eligible expenses for network providers also count toward this limit. Your eligible out-of-pocket expenses will not exceed this amount whether or not you use network providers.

Out of pocket expenses for purposes of this benefit are:

- Your annual deductible
- The copayments you pay for covered in-network services under the Traditional Health Coverage
- The 40% coinsurance you pay for covered out-of-network services under the Traditional Health Coverage, except as described below

The following cannot be included in the accumulation of out-of-pocket expenses. Health care providers can bill you, and you are responsible to pay them even after your expenses exceed the limits described above:

- Expenses in excess of the Plan's allowance or maximum benefit limitations
- Expenses for non-covered services and supplies
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 15-17)
- Coinsurance for skilled nursing care
- Coinsurance for alternative and rehabilitative therapies
- Coinsurance for chiropractic care

Carryover

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

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

If you change plans during the year, you must meet the catastrophic protection out-of-pocket maximum of your new plan in full before catastrophic protection benefits begin.

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 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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

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

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you…

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

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount – the "equivalent Medicare amount" – set by Medicare's rules for what Medicare would pay, not on the actual charge;
- you are responsible for your applicable deductibles, coinsurance, or copayments 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 "equivalent Medicare amount".

And, for your physician care, the law requires us to base our payment and your coinsurance or copayment 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 at 1-800-410-7778.

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.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is Primary, when Medicare does not pay the VA facility.

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.

Standard Option

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

- When Medicare Part A is primary, we will waive applicable per-admission copayments and coinsurance for inpatient hospital benefits, inpatient mental health/substance abuse benefits and nursing benefits.
- When Medicare Part B is primary, we will waive applicable deductibles, copayments and coinsurance for surgical and medical services billed by physicians, durable medical equipment, orthopedic and prosthetic appliances, ambulance services and outpatient mental health/substance abuse services.

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

Standard Option, when you are enrolled in our Medicare Part B pilot program

- We will not waive any deductibles, copayments or coinsurance when you have Medicare Part A and/or B as your primary payor.

Value Plan

- We will not waive any deductibles, copayments or coinsurance when you have Medicare Part A and/or B as your primary payor.

Consumer Option

- We will not waive any deductibles, copayments or coinsurance when you have Medicare Part A and/or B as your primary payor.
- If your physician accepts Medicare assignment, then you pay nothing if you have unused credit available under your HRA to pay the difference between the Medicare approved amount and Medicare's payment. After your HRA is exhausted and your deductible has been met, you pay either the difference between the Medicare approved amount and Medicare's payment or your copayment amount, whichever is less.

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

Standard Option and Value Plan Benefits

This Plan offers a Standard Option and a Value Plan. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The Standard Option and Value Plan Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the *General exclusions* in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-410-7778 or at our Web site at www.mhbp.com.

See pages 9 - 11 for how our benefits changed this year. Pages 143-146 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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

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 applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $400 per person ($800 per family) for services of PPO providers and $600 per person ($1,500 per family) for services of Non-PPO providers.
  - The Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of PPO providers and $900 per person ($1,800 per family) for services of Non-PPO providers.
- 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.

Benefits description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does *not* apply.		
Diagnostic and treatment services	**Standard Option**	**Value Plan**
Professional services of a primary care physician (limited to: general practitioner, family practitioner, internist or pediatrician) in a doctor's office	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: $30 copayment per office visit (No deductible) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Professional services of primary care physicians in other than a doctor's office	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Christian Science Practitioners	Same as above	Same as above
Professional services of specialists: – 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 Note: See Section 5(b) for services related to surgery.	PPO: $40 copayment per office visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: $50 copayment per office visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services – continued on next page

Diagnostic and treatment services *(continued)*	You pay	
	Standard Option	**Value Plan**
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 Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Professional non-emergency services provided in a convenient care clinic (see Definitions, Section 10). For services related to an accidental injury or medical emergency, see Section 5(d).	PPO: $10 copayment per visit (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: $25 copayment per visit (No deductible) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
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 therapies*, page 34.	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: 20% of the Plan's allowance Non-PPO: 40% 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, except as part of a preauthorized treatment plan that we have approved* • *Orthoptic visits and related services* • *Telephone and internet-based consultations*	*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 • CT/CAT Scans; CTA; MRA, MRI; NC; PET Note: Preauthorization for these procedures is required. Call us at 1-800-410-7778 prior to scheduling. • 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: 20% of the Plan's allowance Non-PPO: 40% 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.
Genetic testing Note: Preauthorization for genetic testing is required. Call us at 1-800-410-7778.	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: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Lab, X-ray and other diagnostic tests – continued on next page

Lab, X-ray and other diagnostic tests *(continued)*	You pay	
	Standard Option	**Value Plan**
Lab Savings Program You can use this voluntary program for covered lab tests. 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 and bills us directly, you will not have to file any claims. To find a location near you, call 1-800-377-7220, or visit our Web site at www.mhbp.com.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services provided by a physician are subject to applicable copayments and coinsurance.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services provided by a physician are subject to applicable copayments and coinsurance.
Not covered: • *Handling and administrative charges* • *Routine lab services except as covered under Preventive care* • *Professional fees for automated tests* • *Genetic screening (see Definitions, Section 10)* • *Venipuncture, when billed as a separate procedure along with charges for the related lab test*	*All charges*	*All charges*
Preventive care, adult		
Routine physical examination – one per calendar year for members age 18 and older, limited to: • Patient history and risk assessment • Basic metabolic panel • General health panel Note: Please contact us to obtain information on the specific tests covered under this benefit.	PPO: Nothing (No deductible) Non-PPO: All charges	PPO: Nothing (No deductible) Non-PPO: All charges
Routine screenings, including related office visits, limited to: • Mammogram for women age 35 and older: – From age 35 to 39 – one during this five year period – At age 40 and older – one every calendar year • Pap test – one per calendar year • HPV (human papillomavirus) test – one per calendar year • Prostate Specific Antigen (PSA) test – one per calendar year for men age 40 and older • Colorectal Cancer Screening, including – Fecal occult blood (stool) test — one per calendar year for members age 40 and older – Screening sigmoidoscopy — one every two consecutive calendar years for members age 50 and older – 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 • Osteoporosis screening (bone density study) one every two consecutive calendar years for members age 50 and older • Abdominal aortic aneurysm screening – one per lifetime for men age 65 to 75	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: Expenses for anesthesia and outpatient facility services related to covered colorectal cancer screening are covered under this benefit.	PPO: Nothing (No deductible) Non-PPO: All charges Note: Expenses for anesthesia and outpatient facility services related to covered colorectal cancer screening are covered under this benefit.

Preventative care, adult – continued on next page

Preventive care, adult *(continued)*	**You pay**	
	Standard Option	**Value Plan**
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: All charges
Not covered: • *Routine physical checkups and related tests except those listed above.* • *Routine physical checkups and related tests provided in an urgent care setting*	*All charges*	*All charges*
Preventive care, children		
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: All charges
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: Nothing (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: All charges
Routine Screenings, limited to: • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members • Body mass index testing – one per calendar year for dependent children age 2 through 21	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: All charges
Retinal screening exam for low birth weight premature infants as recommended by the American Academy of Pediatrics	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: All charges
Not covered: • *Routine testing not specifically listed as covered* • *Routine physical checkups and related tests provided in an urgent care setting*	*All charges*	*All charges*

Maternity care	You pay	
	Standard Option	**Value Plan**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Anesthesia • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your admission for a normal delivery; see page 16 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 your admission for a regular delivery and 96 hours after your admission for a cesarean delivery (you do not need to precertify the normal length of stay). We will cover an extended stay for you or your baby if medically necessary, but you, your representative, your doctor, or your hospital must precertify the extended stay. See pages 15-17 for other circumstances. • 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. • The initial newborn exam is payable under this benefit. • We cover circumcision under *Surgical procedures*, Section 5(b). • We cover expenses for inpatient and outpatient hospital services under Section 5(c). • 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 coinsurance and/or copayments. • Maternity benefits will be paid at the termination of pregnancy. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation. Note: IV/infusion therapy and injections for treatment of complications of pregnancy are covered under *Treatment therapies*, Section 5(a).	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: Nothing (No deductible) Non-PPO: 40% 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	**Value Plan**
Voluntary family planning services, limited to: • Voluntary sterilization (see *Surgical procedures*, Section 5(b)) • Surgically implanted contraceptives (see *Surgical procedures*, Section 5(b)) • 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: 20% of the Plan's allowance Non-PPO: 40% 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 the related office visit under *Diagnostic and treatment services*, page 27. Note: We cover oral contraceptive drugs under *Prescription drug benefits*, 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: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Preimplantation genetic diagnosis (PGD)* • *Genetic counseling* • *Genetic screening*	*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*, Section 5(f). Call the Plan for a list of drugs that are covered for this service.	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: 20% of the Plan's allowance Non-PPO: 40% 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 intra-fallopian transfer (GIFT)* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or egg* • *Sperm bank collection and storage fees* • *Surrogacy (host uterus/gestational carrier)*	*All charges*	*All charges*

Allergy care	You pay	
	Standard Option	**Value Plan**
Testing, including materials	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (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 (calendar year deductible applies)	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Allergy serum	PPO: $5 copayment (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Allergy injections (not including the 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 (calendar year deductible applies)	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
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* • *Provocative food testing and sublingual allergy desensitization* • *Clinical ecology and environmental medicine*	*All charges*	*All charges*

Treatment therapies	You pay	
	Standard Option	Value Plan
• Chemotherapy and radiation therapy for treatment of cancer. Note: Call us at 1-800-410-7778 for details about coverage and information about chemotherapy treatments and PPO providers. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 50-52. • 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 department of a hospital, clinic or a physician's office. Pharmacy charges for chemotherapy drugs (including prescription drugs to treat the side effects of chemotherapy) are covered under *Prescription drug benefits*, Section 5(f). Note: Preauthorization is required for hyperbaric oxygen therapy. Call us at 1-800-410-7778 prior to scheduling treatment.	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: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
• Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy (including TPN) • Respiratory therapy • Inhalation therapy • Growth hormone therapy Note: Call us at 1-800-410-7778 for details about coverage and information about dialysis, IV/infusion therapy, respiratory therapy and inhalation therapy PPO providers. Note: These therapies (excluding the related office visits) are covered under this benefit when performed on an outpatient basis. Note: Pharmacy charges for related drugs and medicines, including growth hormones, are covered under *Prescription drug benefits*, Section 5(f). Some drugs, including growth hormones, require preauthorization; see *Specialty drugs*, page 64.	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: 20% of the Plan's allowance Non-PPO: 40% 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 as part of a preauthorized treatment plan that we have approved* • *Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered under Section 5(b)* • *Topical hyperbaric oxygen therapy* • *Prolotherapy*	*All charges*	*All charges*

Rehabilitative therapies	You pay	
	Standard Option	**Value Plan**
Outpatient physical therapy, speech therapy, and occupational therapy Note: The 26-visit per person combined rehabilitative, chiropractic and alternative treatment therapies annual 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 26-visit per person annual benefit maximum. Note: Medically necessary outpatient physical or occupational therapy provided by a skilled nursing facility (SNF) is covered under this benefit if you are not confined in the SNF.	PPO: 10% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies 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 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum	PPO: 20% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount. All charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum
Not covered: • *All charges after the Plan has paid the 26-visit per person rehabilitative, chiropractic and alternative treatment therapies annual maximum* • *Exercise programs* • *Outpatient pulmonary rehabilitation* • *Outpatient cardiac rehabilitation programs* • *Massage therapy*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)		
Hearing exam and testing: • Routine – one per calendar year • Non-routine Note: For coverage of hearing aids, see *Orthopedic and prosthetic devices*, page 37	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (calendar year deductible applies)	PPO: Nothing (No deductible) Non-PPO: Any difference between our allowance and the billed amount (calendar year deductible applies)

Vision services (testing, treatment, and supplies)	You pay	
	Standard Option	**Value Plan**
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)	PPO: All charges over $50 for one set of eyeglasses or $100 for contact lenses (including examination) Non-PPO: 40% of the Plan's allowance and all charges over $50 for one set of eyeglasses or $100 for contact lenses (including examination)
Not covered: • *All charges after the Plan has paid the $50 (eyeglasses) or $100 (contact lenses) benefit maximum* • *Routine eye exams and related office visits* • *Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery* • *Eye exercises* • *Refractions* • *Radial keratotomy including laser keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care		
We pay the professional services for routine foot care for established diabetics. We also pay for medically necessary surgeries under *Surgical procedures*, Section 5(b).	PPO: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible); 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 (calendar year deductible applies)	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
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	You pay	
	Standard Option	**Value Plan**
Orthopedic and prosthetic devices (see *Definitions*, Section 10) when recommended by an MD or DO, including: • Artificial limbs and eyes; stump hose • Custom constructed braces • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, including cochlear implants, if billed by other than a hospital. Insertion of an implanted device is covered under *Surgical procedures*, Section 5(b). Note: Call us at 1-800-410-7778 for details about coverage and information about orthopedic and prosthetic PPO providers. Note: We will only cover the cost of a standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item.	PPO: 10% of the Plan's allowance Non-PPO: 10% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Hearing aids – one hearing aid per ear every five (5) calendar years. Note: The calendar year deductible applies.	All charges over $500 for one hearing aid per ear	All charges over $500 for one hearing aid per ear
Not Covered: • *Orthopedic and corrective shoes unless attached to a brace* • *Arch supports, heel pads and heel cups* • *Foot orthotics and related office visits* • *Lumbosacral supports, corsets, trusses, elastic stockings, support hose, non-custom hinged knee braces, and other supportive devices* • *Compression/support sleeves, except for treatment of lymphedema and severe burns* • *Prosthetic replacements provided less than 3 years after the last one we covered unless a replacement is needed for medical reasons* • *Penile prosthetics* • *Customization or personalization beyond what is necessary for proper fitting and adjustment of the items* • *Hearing aid replacements within five years after the Plan has paid the $500 per ear hearing aid maximum, replacement batteries, service contracts*	*All charges*	*All charges*

Durable medical equipment (DME)	You pay	
	Standard Option	**Value Plan**
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 of durable medical equipment, at our option, including repair and adjustment, such as: • Oxygen and oxygen equipment; • Dialysis equipment; • Wheelchairs; • Hospital beds; • Ostomy supplies (including supplies purchased at a pharmacy). • Audible prescription reading devices For items that are available for purchase we will limit our benefit for the rental of durable medical equipment to an amount no greater than what we would have paid if the equipment had been purchased. For coordination of benefits purposes, when we are the secondary payor, we will limit our allowance for rental charges to the amount we would have paid for the purchase of the equipment, except when the primary payor is Medicare Part B and Medicare elects to continue renting the item. Note: Call us at 1-800-410-7778 for details about coverage and 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 payor, diabetic supplies will be covered under this benefit. Note: See *Treatment therapies*, page 34 for coverage of hyperbaric oxygen therapy. Note: We will only cover the cost of standard equipment. Coverage for specialty items such as all terrain wheelchairs is limited to the cost of the standard equipment. Note: Preauthorization is required for audible prescription reading devices. Call us at 1-800-410-7778.	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: 20% of the Plan's allowance Non-PPO: 40% 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 (DME) *(continued)*	**You pay**	
	Standard Option	**Value Plan**
Augmentative and alternative communication (AAC) devices	PPO: All charges after the Plan has paid $500 per device Non-PPO: All charges after the Plan has paid $500 per device	PPO: All charges after the Plan has paid $500 per device Non-PPO: All charges after the Plan has paid $500 per device
Not covered: • *Equipment replacements provided less than 3 years after the last one we covered* • *Charges for service contracts for purchased or rented equipment, except for purchased oxygen concentrators* • *Safety, hygiene, convenience and exercise equipment; bedside commodes* • *Household or vehicle modifications including seat, chair or van lifts; car seats; computer switchboard* • *Air conditioners, air purifiers, humidifiers, ultraviolet lighting (except for the treatment of psoriasis), heating pads, hot/cold packs, sun or heat lamps* • *Wigs or hair pieces* • *Motorized scooters (see Definitions, Section 10), 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 or charges in excess of the secondary payor amount when we are the secondary payor, except as noted on page 38* • *Customization or personalization of equipment* • *Blood pressure monitors* • *Enuresis alarms* • *Breast pumps* • *All charges for AAC devices after the Plan has paid $500 per device*	*All charges*	*All charges*

Home health services – (nursing services)	You pay	
	Standard Option	**Value Plan**
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 the services are needed; and • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services. Note: Benefits are limited to 6 visits (Standard Option) or 4 visits (Value Plan) per person per calendar year Note: Services of a Christian Science Nurse are covered under this benefit.	PPO: 10% of the Plan's allowance and all charges after 6 visits Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after 6 visits	PPO: 20% of the Plan's allowance and all charges after 4 visits Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after 4 visits
Not covered: • *Inpatient private duty nursing* • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services and supplies primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *All charges after 6 visits (Standard Option) or 4 visits (Value Plan) per person per calendar year*	*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 26-visit per person combined rehabilitative, chiropractic and alternative treatment therapies annual maximum includes all covered services and supplies billed for these therapies.	PPO: $20 copayment per visit and all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum (No deductible) 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 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum (No deductible)	PPO: 20% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum Non-PPO: All charges

Alternative treatments	You pay	
	Standard Option	Value Plan
Acupuncture Note: The 26-visit per person combined rehabilitative, chiropractic and alternative treatment therapies annual 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 26-visit combined rehabilitative, chiropractic and alternative treatment therapies 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 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum	PPO: 20% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum
Not covered: • *Naturopathic and homeopathic services* • *Chelation therapy and related services, except as part of a preauthorized treatment plan that we have approved* • *Thermography, biofeedback and related visits* • *Massage therapy, acupressure, hypnotherapy* • *Self care or home management training or programs* • *All charges after the Plan has paid the 26-visit per person combined rehabilitative, chiropractic and alternative treatment therapies annual maximum* *Note: Services of certain alternative treatment providers may be covered in medically underserved areas — see page 13.*	*All charges*	*All charges*

Educational classes and programs	You pay	
	Standard Option	Value Plan
Smoking cessation • QuitPower® smoking cessation program covers up to two quit attempts per member per calendar year, including up to four counseling sessions per quit attempt and over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Members may enroll in the QuitPower® program by calling 1-877-784-8797.	Nothing (No deductible)	Nothing (No deductible)
• Physician-prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence may also be obtained from a retail pharmacy or through our mail order drug program.	PPO: Nothing (No deductible) Non-PPO: Only the difference between the Plan's allowance and the billed amount (No deductible)	PPO: Nothing (No deductible) Non-PPO: All charges
Diabetic education provided by a physician for members with an established diagnosis of diabetes, including: • Educational supplies • Patient instruction • Medical nutrition therapy Note: Please contact us to obtain information on the specific services covered under this benefit.	PPO: 10% of the Plan's allowance Non-PPO: All charges	PPO: 20% of the Plan's allowance Non-PPO: All charges
Not covered: • *Self help or self management programs except diabetic education described above* • *Charges for educational/instructional advice on how to use durable medical equipment* • *Programs for nocturnal enuresis*	*All charges*	*All charges*

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

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 applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $400 per person ($800 per family) for services of PPO providers and $600 per person ($1,500 per family) for services of Non-PPO providers.
  - The Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of PPO providers and $900 per person ($1,800 per family) for services of Non-PPO providers.
- 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 surgical care. Look in Section 5(c) for charges associated with the facility (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.

Benefits description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**Standard Option**	**Value Plan**
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; • Removal of tumors and cysts; • Correction of congenital anomalies (see *Reconstructive surgery*); • 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 severe burns; • Correction of amblyopia & strabismus. Note: Preauthorization is required for all spinal surgeries. Call us at 1-800-410-7778.	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: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-PPO: 40% 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	**Value Plan**
Surgical treatment of morbid obesity (bariatric surgery) – a diagnosed condition in which the body mass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction – when: – Morbid obesity has persisted for at least 3 years – There is no treatable metabolic cause for the obesity – Member has participated in a 3-month physician-supervised weight loss program that included dietary therapy, physical activity and behavior therapy within the past 6 months and has failed to lose weight – A psychological evaluation has been completed and member has been recommended for bariatric surgery – Member is age 18 or older Call us at 1-800-410-7778 for additional information about surgical treatment of morbid obesity. Note: Coverage is limited to one surgical treatment for morbid obesity per member per lifetime. Note: Preauthorization for surgical treatment of morbid obesity is required. Call us at 1-800-410-7778.	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: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-PPO: 40% 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 and any other subsequent procedures: – PPO: one-half of the Plan's allowance, unless the PPO contract provides for a different amount, or – Non-PPO: one-half 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 our allowance and the billed amount	PPO: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for the individual procedure for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-PPO: 40% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount

Surgical Procedures – continued on next page

Surgical procedures *(continued)*	**You pay**	
	Standard Option	**Value Plan**
Co-surgeons When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 62.5% of what it would pay a single surgeon for the same procedure(s), unless the PPO contract provides for a different 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	PPO: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Assistant surgeons Assistant surgical services provided by a qualified surgeon (M.D.) when medically necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan's allowance for the assistant surgeon is 16% of the allowance for the surgery, unless the PPO contract provides for a different amount.	PPO: Nothing (calendar year deductible applies) Non-PPO: The difference between our allowance and the billed amount	PPO: Nothing (No deductible) 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 46)* • *Radial keratotomy, laser and other refractive surgery* • *Assistant surgeon services from a non-physician provider, such as a Physician Assistant (P.A.), Certified Registered Nurse First Assistant (C.R.N.F.A.) and a Certified Surgical Technologist (C.S.T.)*	*All charges*	*All charges*

Reconstructive surgery	You pay	
	Standard Option	**Value Plan**
• 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 of breasts – Treatment of any physical complications, such as lymphedemas (see *Orthopedic and prosthetic devices*, Section 5(a) 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 for up to 48 hours after your admission.	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: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-PPO: 40% 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 change in bodily form, except repair of accidental injury or caused by illness* • *Surgery related to sex transformations or sexual dysfunction* • *Charges for photographs to document physical conditions*	*All charges*	*All charges*

Oral and maxillofacial surgery	You pay	
	Standard Option	**Value Plan**
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: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-PPO: 40% 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* • *Conservative treatment of temporomandibular joint dysfunction (TMJ)* • *Dental/oral surgical splints and stents* • *Orthodontic treatment*	*All charges*	*All charges*

Organ/tissue transplants

Prior Authorization

All transplant procedures and transplant-related services, except corneal transplants, are subject to medical necessity and experimental/investigational review, and must be preauthorized. You, your representative, the doctor, or the hospital must contact us before your evaluation as a potential candidate for a transplant procedure so we can arrange to review the evaluation results and determine whether the proposed procedure is approved for coverage. You must have our written approval for the procedure before the Plan will cover any transplant-related expenses.

Coventry Transplant Network

- The Plan participates in the Coventry Transplant Network. Because transplantation is a highly specialized area, not all PPO hospitals are part of the Coventry Transplant Network.
- **To qualify for this program, you, your representative, the doctor, or the hospital 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 and participating facilities.
- To receive the Coventry Transplant Network level of benefits, you must choose a Coventry Transplant Network facility, and all transplant-related services must be received at that facility.
- All transplant admissions must be precertified.
- To use the Coventry Transplant Network, this must be your primary plan for payment of benefits.
- **Travel Benefit** – for patients using the Coventry Transplant Network, the Plan may approve reasonable travel, lodging and meal expenses (if the recipient lives more than 50 miles one-way 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.

Donor Coverage

- We cover donor screening and search expenses for up to four (4) candidate donors per transplant occurrence.
- We cover related medical and hospital expenses of the donor for the initial transplant confinement when we cover the recipient if these expenses are not covered under any other health plan.

Benefit Limitations

- The maximum benefit for any organ/tissue transplant(s) is:
  - Coventry Transplant Network: $1,000,000 per occurrence, which includes the following transplant-related expenses: pre-transplant evaluation, inpatient and outpatient hospital care, postoperative follow-up care, professional fees and donor expenses. To use the Coventry Transplant Network, this must be your primary plan for payment of benefits.
  - PPO and Non-PPO: $200,000 per occurrence for PPO services or $100,000 per occurrence for Non-PPO services. These benefit maximums include:

    Solid organ transplants: all transplant-related expenses from the date of the transplant procedure until the date of discharge from the hospital following the procedure.

    Autologous blood or marrow stem cell transplants: all inpatient and outpatient transplant-related services from the date of mobilization of stem cells to three months after the date of cell infusion.

    Allogeneic blood or marrow stem cell transplants: all inpatient and outpatient transplant-related services from the date of pre-transplant high-dose ablation chemotherapy to three months after the date of cell infusion.
- 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. See Section 5(c) for coverage of transplant-related services provided by a hospital.

Note: Benefits will be paid at the PPO or Non-PPO level of benefits if no Coventry Transplant Network provider is available.

Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support, is covered only for the specific diagnoses listed.

Note: Donor Leukocyte Infusion (DLI, sometimes referred to as a "boost" to a past bone marrow transplant) is covered under Section 5(a) and Section 5(c).

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You pay	
	Standard Option	**Value Plan**
Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Liver/kidney • Pancreas* • Kidney/Pancreas • Lung: single, double, lobar • Intestinal transplants – small intestine – small intestine with the liver – small intestine with multiple organs such as the liver, stomach, and pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis Note: Corneal transplants are not part of the Coventry Transplant Network. Benefits will be paid as described on page 43. *Note: Pancreas (only) transplants are covered for insulin dependent (or Type 1) diabetes mellitus when exogenous treatment with insulin is deemed ineffective by the Plan.	Coventry Transplant Network: 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	Coventry Transplant Network: 10% of the Plan's allowance and all charges over $1,000,000 PPO: 20% of the Plan's allowance and all charges over $200,000 Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You pay	
	Standard Option	**Value Plan**
Blood or marrow stem cell transplants, limited to the indicated stages of the following diagnoses (the medical necessity limitation is considered satisfied if the patient meets the staging description): • Allogeneic (donor) transplants for: – chronic or acute myelogenous leukemia – acute lymphocytic leukemia – acute myeloid leukemia – chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – severe or very severe aplastic anemia – severe combined immuno-deficiency disease – phagocytic/hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) – advanced Hodgkin's lymphoma – advanced non-Hodgkin's lymphomas – hemoglobinopathy (i.e., Fanconi's syndrome, thalassemia major) – myelodysplasia/myelodysplastic syndromes – amyloidosis – paroxysmal nocturnal hemoglobinuria – infantile malignant osteopetrosis – advanced neuroblastoma – Kostmann's syndrome – leukocyte adhesion deficiencies – mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) – mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) – myeloproliferative disorders (MPDs) – sickle cell anemia • Autologous (self) transplants (autologous stem cell and peripheral stem cell support) for: – acute myelogenous leukemia – chronic or acute lymphocytic leukemia – advanced Hodgkin's lymphoma – advanced non-Hodgkin's lymphomas – advanced neuroblastoma – testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors – multiple myeloma – amyloidosis • Autologous tandem bone marrow transplants for: – multiple myeloma – de novo myeloma – recurrent testicular and other germ cell tumors	Coventry Transplant Network: 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	Coventry Transplant Network: 10% of the Plan's allowance and all charges over $1,000,000 PPO: 20% of the Plan's allowance and all charges over $200,000 Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You pay	
	Standard Option	**Value Plan**
Blood or marrow stem cell transplants in randomized and controlled Phase III clinical trials that are sponsored by the National Cancer Institute (NCI) or the National Institutes of Health (NIH), limited to: • Allogeneic (donor) transplants for: – early stage (indolent or non-advanced) small cell lymphocytic lymphoma – multiple myeloma – advanced myelodysplastic syndromes (e.g, DeNovo, secondary, high dose) not previously treated – myelodysplasia/myelodysplastic syndromes – chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – chronic myelogenous leukemia – chronic and juvenile myelomonocytic leukemia – multiple sclerosis – hemoglobinopathies • Nonmyeloablative allogeneic transplants or Reduced Intensity Conditioning (RIC) for: – acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – advanced forms of myelodysplastic syndromes – advanced Hodgkins lymphoma – advanced non-Hodgkins lymphoma – breast cancer – chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – chronic myelogenous leukemia – colon cancer – early stage (indolent or non-advanced) small cell lymphocytic lymphoma – multiple myeloma – multiple sclerosis – myeloproliferative disorders – myelodysplasia/myelodysplastic syndromes – non-small cell lung cancer – ovarian cancer – prostate cancer – renal cell carcinoma – sarcomas – pediatric sickle cell disease	Coventry Transplant Network: 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	Coventry Transplant Network: 10% of the Plan's allowance and all charges over $1,000,000 PPO: 20% of the Plan's allowance and all charges over $200,000 Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You pay	
	Standard Option	**Value Plan**
Blood or marrow stem cell transplants in randomized and controlled Phase III clinical trials that are sponsored by the National Cancer Institute (NCI) or the National Institutes of Health (NIH), limited to: • Autologous transplants for: – chronic myelogenous leukemia – chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – early stage (indolent or non-advanced) small cell lymphocytic lymphoma – small cell lung cancer – breast cancer – epithelial ovarian cancer – multiple sclerosis – systemic lupus erythematosis – systemic sclerosis – amyloidosis (single) – scleroderma – scleroderma-SSc (severe, progressive)	Coventry Transplant Network: 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	Coventry Transplant Network: 10% of the Plan's allowance and all charges over $1,000,000 PPO: 20% of the Plan's allowance and all charges over $200,000 Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000
Not covered: • *Expenses for services or supplies specifically excluded by the Plan, unless part of a treatment plan approved through the Coventry Transplant Network* • *Donor screening and search expenses after four screened donors, except when approved through the Coventry Transplant Network* • *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		
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 If you use a PPO facility, we pay PPO benefits when you receive services from an anesthesiologist who is not a PPO provider. See *Preferred Provider Organization*, Section 1, for further details.	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount If you use a PPO facility, we pay PPO benefits when you receive services from an anesthesiologist who is not a PPO provider. See *Preferred Provider Organization*, Section 1, for further details.

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

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. We added "(calendar year deductible applies)". If applicable:
  - the Standard Option calendar year deductible is $400 per person ($800 per family) for services of PPO providers and $600 per person ($1,500 per family) for services of Non-PPO providers.
  - the Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of PPO providers and $900 per person ($1,800 per family) for services of Non-PPO providers.
- The Non-PPO benefits 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. To help keep your out-of-pocket costs for coinsurance to a minimum, we encourage you to contact us for direction to PPO providers whenever possible.
- 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 Section 5(a) or Section 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.

Benefits description	You pay	
Note: The calendar year deductible applies ONLY when we say below:-"(calendar year deductible applies)".		
Inpatient hospital	**Standard Option**	**Value Plan**
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, our benefit will be based on the hospital's average charge for semiprivate accommodations. Note: Hospitals billing an all-inclusive rate will be prorated between room and board and ancillary charges.	Coventry Transplant Network: Nothing PPO: Nothing Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Coventry Transplant Network: 10% of the Plan's allowance (calendar year deductible applies) PPO: 20% of the Plan's allowance (calendar year deductible applies) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You pay**	
	Standard Option	**Value Plan**
Other hospital services and supplies (ancillary services), such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic tests, such as X-rays, laboratory and pathology services, MRIs, and CAT Scans • 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 our 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, we pay under Section 5(b). Note: The maximum benefit for any organ/tissue transplant(s) as described on page 48 is: • Coventry Transplant Network: $1,000,000 per occurrence. To use the Coventry Transplant Network, this must be your primary plan for payment of benefits. • PPO and Non-PPO: $200,000 per occurrence for PPO services or $100,000 per occurrence for Non-PPO services. 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. See Section 5(b) for transplant-related professional services. Note: To use the Coventry Transplant Network, this must be your primary plan for payment of benefits. Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support is covered only for the specific diagnoses listed on pages 50-52. 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. Note: Benefits for admission to Christian Science nursing facilities are limited to $30,000 per person per calendar year.	Coventry Transplant Network: $200 copayment per admission and 10% of the Plan's allowance PPO: $200 copayment per admission and 15% of the Plan's allowance Note: For inpatient hospital care related to maternity, including care at birthing facilities, we waive the per-admission copayment and the coinsurance and pay for covered services in full for care provided by a PPO facility. Non-PPO: $500 copayment per admission plus 30% of the Plan's allowance and any difference between our allowance and the billed amount	Coventry Transplant Network: 10% of the Plan's allowance (calendar year deductible applies) PPO: 20% of the Plan's allowance (calendar year deductible applies) Note: For inpatient hospital care related to maternity, including care at birthing facilities, we waive the calendar year deductible and the coinsurance and pay for covered services in full for care provided by a PPO facility. Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	You pay	
	Standard Option	**Value Plan**
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 after the Plan has paid $30,000 for services provided by a Christian Science nursing facility*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center		
Services and supplies related to outpatient surgical procedures, provided on the same day as the procedure, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic tests, such as X-rays, laboratory and pathology services, MRIs, and CAT Scans • Blood and blood plasma, if not donated or replaced, and other biologicals, including administration • 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 and you are admitted, you need to precertify the admission. Note: For services billed by a surgeon or anesthetist, see Section 5(b). For services related to an accidental injury or medical emergency, see Section 5(d).	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: $300 copayment per occurrence (No deductible) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Outpatient hospital or ambulatory surgical center – continued on next page

Outpatient hospital or ambulatory surgical center *(continued)*	**You pay**	
	Standard Option	**Value Plan**
Services and supplies related to outpatient maternity care, including care at birthing facilities, such as: • Delivery, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic tests, such as X-rays, ultrasound, laboratory and pathology services • Medical supplies, including anesthesia and oxygen Note: For services billed by a surgeon or anesthetist, see Section 5(b).	PPO: Nothing (No 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 (No deductible) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Services and supplies related to outpatient diagnostic testing and rehabilitative therapy, such as: • Diagnostic tests, such as X-rays, laboratory and pathology services, MRIs, and CAT Scans • Physical, speech and occupational therapy Note: The 26-visit per person combined rehabilitative, chiropractic and alternative therapies annual maximum includes all covered services and supplies billed for these therapies. • Treatment rooms Note: If the stay is greater than 23 hours and you are admitted, you need to precertify the admission. Note: For services related to an accidental injury or medical emergency, see Section 5(d).	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: 20% of the Plan's allowance (calendar year deductible applies) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Services and supplies for outpatient treatment services not related to surgical procedures, such as: • Treatment and observation rooms • Chemotherapy and radiation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy • Hyperbaric oxygen therapy • Respiratory and inhalation therapy • Growth hormone therapy • Medical supplies, including oxygen Note: If the stay is greater than 23 hours and you are admitted, you need to precertify the admission. Note: For services related to an accidental injury or medical emergency, see Section 5(d).	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: 20% of the Plan's allowance (calendar year deductible applies) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: *Surgical facility charges billed by entities that are not accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory Health Care (AAAHC), or which do not have Medicare certification as an ASC facility.*	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits		
No benefit	*All charges*	*All charges*

Hospice care	You pay	
	Standard Option	**Value Plan**
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* • *All charges after the Plan has paid $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. Services must be related to a covered inpatient hospitalization, a medical emergency, or associated with covered hospice care. 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. Note: Benefits for air or ground ambulance transportation that is not to the nearest hospital where appropriate treatment is available will be prorated based on mileage to the nearest hospital where appropriate treatment is available.	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: 20% of the Plan's allowance (calendar year deductible applies) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Transportation to other than a hospital, hospice or urgent care medical facility* • *Wheelchair van service; gurney van service*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

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.
- These benefits are payable instead of any other benefit under this Plan for emergency treatment of accidental injuries and medical emergencies.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $400 per person ($800 per family) for services of PPO providers and $600 per person ($1,500 per family) for services of Non-PPO providers.
  - The Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of PPO providers and $900 per person ($1,800 per family) for services of Non-PPO providers.
- 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.

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.

What is a medical emergency? A medical emergency is the sudden and unexpected onset of a condition requiring immediate medical care. The severity of the condition, as revealed by the doctor's diagnosis, must be such as would normally require emergency care. Medical emergencies include heart attacks, cardiovascular accidents, loss of consciousness or respiration, convulsions and such other acute conditions as may be determined by the Plan to be medical emergencies.

Benefits description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury	**Standard Option**	**Value Plan**
If you receive outpatient care for your accidental injury in a hospital emergency room, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery and related services Note: We pay Hospital benefits if you are admitted. See Section 5(c). 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 services were rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	PPO: $200 copayment per occurrence (No deductible) (if admitted to the hospital, copayment is waived) Non-PPO: $200 copayment per occurrence (No deductible) and any difference between our allowance and the billed amount (if admitted to the hospital, copayment is waived)	PPO: 20% of the Plan's allowance Non-PPO: 20% 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	**Value Plan**
If you receive outpatient care for your accidental injury in an urgent care center, we cover: • Non-surgical physician services and supplies • Surgery and related services 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 services were rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	PPO: $50 copayment per occurrence (No deductible) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Non-surgical physician services provided in a doctor's office for your accidental injury	PPO: $20 copayment per office visit for adults (No deductible), $10 copayment per office visit for dependent children under age 22 (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: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Medical emergency		
If you receive outpatient care for your medical emergency in a hospital emergency room, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery and related services Note: We pay Hospital benefits if you are admitted. See Section 5(c).	PPO: $200 copayment per occurrence (if admitted to the hospital, copayment is waived) Non-PPO: $200 copayment per occurrence and any difference between our allowance and the billed amount (if admitted to the hospital, copayment is waived)	PPO: 20% of the Plan's allowance Non-PPO: 20% of the Plan's allowance and any difference between our allowance and the billed amount
If you receive outpatient care for your medical emergency in an urgent care center, we cover: • Non-surgical physician services and supplies • Surgery and related services	PPO: $50 copayment per occurrence Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Medical emergency *(continued)*	**You pay**	
	Standard Option	**Value Plan**
Non-surgical physician services provided in a doctor's office for your medical emergency.	PPO: $20 copayment per office visit for adults (No deductible), $10 copayment per office visit for dependent children under age 22 (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: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
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. Services must be related to a covered inpatient hospitalization, a medical emergency, or associated with covered hospice care. 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. Note: Benefits for air or ground ambulance transportation that is not to the nearest hospital where appropriate treatment is available will be prorated based on mileage to the nearest hospital where appropriate treatment is available.	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: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • Transportation to other than a hospital, hospice or urgent care medical facility • *Wheelchair van service; gurney van service*	All charges	All charges

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

Your cost-sharing responsibilities for mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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 and/or clinically appropriate.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $400 per person ($800 per family) for services of In-Network providers and $600 per person ($1,500 per family) for services of Out-of-Network providers.
  - The Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of In-Network providers and $900 per person ($1,800 per family) for services of Out-of-Network providers.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- YOU MUST GET 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.

Benefits description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional services	**Standard Option**	**Value Plan**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	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.
Diagnostic and treatment services: • Outpatient professional services, including individual or group therapy. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist. • Medication management	In-Network: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children under age 22 (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	In-Network: $30 copayment per visit (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
• Inpatient professional services	In-Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	In-Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Diagnostics		
Outpatient lab, X-ray and other diagnostic tests, including psychological testing	In-Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	In-Network: Nothing (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Mental health and substance abuse benefits – continued on next page

Inpatient hospital	You pay	
	Standard Option	**Value Plan**
Inpatient hospital: • 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 Note: Preauthorization for these services is required. Call us at 1-800-410-7778 prior to scheduling.	In-Network: $200 copayment per admission, nothing for room and board and 15% of the Plan's allowance for hospital ancillary services (No deductible) Non-Network: $500 copayment per admission plus 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	In-Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Outpatient hospital		
• Electroshock therapy Note: Preauthorization for these services is required. Call us at 1-800-410-7778 prior to scheduling.	In-Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	In-Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Benefits for surgical treatment of mental health/substance abuse conditions are available only for Vagus Nerve Stimulation therapy (VNS) when preauthorized as part of a treatment plan that we approve. For services billed by a surgeon or anesthetist, see Section 5(b). For services provided by the outpatient department of a hospital or ambulatory surgical center, see Section 5(c).		
Not covered		
• *Services that, in the Plan's judgment, are not medically necessary* • *Services provided by Non-Network pastoral, marital, drug/alcohol and other counselors* • *Treatment for learning disabilities and mental retardation* • *Services rendered or billed by schools* • *Services provided by Non-Network residential treatment centers or halfway houses or members of their staffs*	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 65.
- 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 calendar year deductible for prescription drugs.
- YOU MUST GET PREAUTHORIZATION FOR CERTAIN 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.

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 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 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 the full cost and must file a claim for reimbursement. See Section 7, *Filing a claim for covered services.*

  Mail order – To obtain more information about the mail order drug program, order refills, check order status and request additional mail service 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 is updated periodically and 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;

  Specialty drug category (see description of Specialty drugs on page 64).

  Occasionally, drugs may change from one category to another category during the year; this can affect your copayment amount. We will attempt to notify you when this occurs.

  Please note: Information about the program and a copy of the formulary was included with your identification card. When you need a prescription, share the formulary with your provider and request a Generic or Preferred category drug if possible. By choosing Generic or Preferred category drugs, you may decrease your out-of-pocket expenses. While all FDA-approved drugs are included on the formulary list, we may have restrictions on certain drugs, including but not limited to, quantity limits, age limits, dosage limits and preauthorization. To request a copy of our current formulary, call us at 1-800-410-7778 or visit our Web site, www.mhbp.com.

- **Maintenance and long-term medications.** A long-term maintenance medication is one that is taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma, diabetes or high cholesterol. We have an optional program that allows members to get up to 90-day refills at a CVS retail pharmacy for the same cost-sharing as mail order. Under the program, you may choose to get the initial prescription and two refills (up to a 30-day supply) at a network retail pharmacy or a non-network retail pharmacy, or through our mail order drug program in up to a 90-day supply. After the second refill at a retail pharmacy, additional refills must be obtained either from a CVS retail pharmacy or through our mail order drug program. You will receive a letter after your second fill that describes your benefits and provides instructions on how to obtain additional refills in up to a 90-day supply. You may choose **not** to participate in this program by calling CVS Caremark at 1-866-623-1441. If you exceed three fills at a network retail pharmacy and have not advised us that you do not want to participate in this program, you may experience a delay in receiving your medication until you contact us.
- **Generic drug incentive program.** You may be eligible for this program if you are currently taking a non-generic medication and switch to a generic replacement for that drug. If you qualify, you can receive up to a 90-day supply of the generic drug at no cost to you. You must obtain the generic replacement at a network retail pharmacy (for up to three 30-day refills), or through our mail order drug program (for one 90-day refill). To find out if you qualify for this program, call CVS Caremark at 1-866-623-1441.

Prescription drug benefits – continued on the next page

Prescription drugs *(continued)*

- **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 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.
- **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 diagnoses. Since the prescription does not usually explain the reason your provider prescribed a medication, we may implement any of these limits and/or require preauthorization to confirm the intent of the prescriber.
- **Specialty drugs**, including biotech drugs, require special handling and close monitoring, and are used to treat chronic complex conditions including, but not limited to: hemophilia, immune deficiency, growth hormone deficiencies, multiple sclerosis, Crohn's disease, hepatitis C, HIV, hormonal disorders, rheumatoid arthritis and pulmonary disorders. **These drugs require preauthorization to determine medical necessity and appropriate utilization**. **Specialty drugs must be obtained from CVS Caremark Specialty Pharmacy**. In addition to specialty drugs, we require preauthorization for certain classes of drugs, including, but not limited to: growth hormones; replacement enzymes; physical adjuncts; immunomodulators; drugs used to treat Attention Deficit Disorder and narcolepsy; oncologic agents; endothelin receptor antagonists; neuromuscular blocking agents; and monoclonal antibodies to IGE.
  Call us at 1-800-410-7778 if you have any questions regarding preauthorization, quantity limits, or other issues.
- We can accommodate your drug refill requests when you are called to active military duty or in the case of a declared emergency. You can call us while you are in the pharmacy or in advance at 1-800-410-7778 to request the accommodation.
- **The Plan conducts Drug Utilization Review (DUR).** 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 CVS/Caremark 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. In addition, 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. For more information about this program, call us at 1-800-410-7778.
- **When you do have to file a claim.** If you purchase prescriptions at a non-network pharmacy, mail your prescription receipts to: CVS Caremark, Attn: Claims Department, P.O. Box 52196, Phoenix, AZ 85072-2196 . Receipts must include the prescription number, name of drug, date, prescribing doctor's name, charge, name and address of drugstore and NDC number (included on the bill). See *How to claim benefits*, Section 7, for additional information.

Benefits for all prescription drugs will be determined based on the fill date for the prescription.

Note: All drugs may not be available through the mail order program. Some of the drug classes that may not be 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.

Prescription drugs purchased at a retail pharmacy. The Plan's benefit for prescription drugs purchased at a retail pharmacy is dependent on: whether or not you use a network pharmacy; whether or not the claim is filed electronically by the pharmacy; and, for prescription drugs purchased at non-U.S. pharmacies, whether or not you reside in the United States.

- Network pharmacy; claims filed electronically by the pharmacy — You will receive the maximum level of benefits when you use a network pharmacy and have the pharmacy file the claim electronically for you.
- Non-Network pharmacy and claims not filed electronically by a network pharmacy — Benefits will be paid at the non-network benefit level when you do not use a network pharmacy and have the pharmacy file the claim electronically for you. This includes prescriptions purchased at a network pharmacy when the claim is not filed electronically by the pharmacy. There is no benefit for prescriptions filled at a non-network pharmacy under Value Plan.
- Prescriptions filled at a foreign pharmacy — When you reside outside the United States and have your prescription filled at a foreign pharmacy, you will receive the Network Pharmacy level of benefits, even if your claim is not filed electronically by the pharmacy. When you do not reside outside the United States and have your prescription filled at a foreign pharmacy, you will receive the non-network level of benefits.

Remember to use a network pharmacy whenever possible and show your Mail Handlers Benefit Plan ID card to receive the maximum benefits and the convenience of having your claims filed for you.

Prescription drug benefits begin on the next page

Benefits description	You pay	
Note: The calendar year deductible does not apply to benefits in this Section.		
Covered medications and supplies	**Standard Option**	**Value Plan**
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 • Oral contraceptive (Implants and implant insertions are covered under *Surgical procedures,* Section 5(b)) • Diaphragms For questions about the prescription drug program, or to obtain a copy of our current formulary, please call us at 1-800-410-7778 or visit our Web site at www.mhbp.com. Note: Physician-prescribed over-the-counter or prescription drugs approved by the FDA to treat tobacco dependence are covered under *Educational classes and programs,* page 42. Note: When Medicare Parts A and B are your primary coverage, prescription drug benefits will be paid as described in this section. Note: Services billed electronically by VA facilities will be paid at the network level of benefits. Services billed by DoD and IHS facilities will be paid at the non-network level of benefits. *Note: For long-term maintenance medications, we have an optional maintenance drug management program that allows members to get up to 90-day refills at a CVS retail pharmacy for the same cost-sharing as mail order. Under the program, you may choose to get the initial prescription and two refills (up to a 30-day supply) at a network retail pharmacy or a non-network retail pharmacy, or through our mail order drug program in up to a 90-day supply. After the second refill at a retail pharmacy, additional refills must be obtained either from a CVS retail pharmacy or through our mail order drug program. Members may choose **not** to participate in this program by calling CVS Caremark at 1-866-623-1441.	Network pharmacies or prescriptions filled by foreign pharmacies, up to a 30-day supply*: – Generic: $10 copayment per prescription – Preferred brand name: 30% of the Plan's allowance, limited to $200 per prescription – Non-Preferred brand name: 50% of the Plan's allowance, limited to $200 per prescription – Specialty: $150 copayment per prescription Non-network pharmacies/Paper claims for prescriptions filled at a network pharmacy: – 50% of the Plan's allowance for the prescription and any difference between our allowance and the billed amount Mail order drug program, up to a 90-day supply: – Generic: $15 copayment per prescription – Preferred brand name: $80 copayment per prescription – Non-Preferred brand name: $120 copayment per prescription – Specialty: $400 copayment per prescription Note: There is a $5,000 per person per calendar year catastrophic protection limit on out-of-pocket expenses for Specialty drugs obtained from a Network retail pharmacy or through our mail order drug program under Standard Option. This limit does not apply to drugs obtained from any other source.	Network pharmacies or prescriptions filled by foreign pharmacies, up to a 30-day supply*: – Generic: $10 copayment per prescription – Preferred brand name, Non-Preferred brand name and Specialty: 50% of the Plan's allowance Non-network pharmacies/Paper claims for prescriptions filled at a network pharmacy: – All charges Mail order drug program, up to a 90-day supply: – Generic: $30 copayment per prescription – Preferred brand name, Non-Preferred brand name and Specialty: 50% of the Plan's allowance Note: There is a $7,000 per person per calendar year catastrophic protection limit on out-of-pocket expenses for drugs obtained from a Network retail pharmacy or through our mail order drug program under Value Plan. This limit does not apply to drugs obtained from any other source.

Prescription drug benefits – continued on the next page

Benefits description	You pay	
Note: The calendar year deductible does not apply to benefits in this Section.		
Covered medications and supplies	**Standard Option**	**Value Plan**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Prescriptions written by a non-covered provider* • *Vitamins, nutrients and food supplements that do not require a physician's prescription, even if a physician prescribes or administers them* • *Total parenteral nutrition (TPN) products and related services* • *Nonprescription drugs or medicines* • *Anorexiants or weight loss medications* • *Erectile dysfunction drugs* • *Drugs and supplies when another insurance plan or payor provides benefits, regardless of actual payment, for these services/supplies except Medicare covered drugs and supplies (see Durable medical equipment, Section 5(a), for Medicare 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* • *Drugs for which preauthorization has been denied*	*All charges*	*All charges*

Section 5(g). Dental benefits

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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) dental plan, your FEHB Plan will be the first/primary payor of any benefit payments and your FEDVIP plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage*.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $400 per person ($800 per family) for services of PPO providers and $600 per person ($1,500 per family) for services of Non-PPO providers.
  - The Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of PPO providers and $900 per person ($1,800 per family) for services of Non-PPO providers.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Note: We cover hospitalization for dental procedures only when 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 inpatient hospital benefits.

Accidental injury benefit	You pay	
	Standard Option	Value Plan
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. 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 services are rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	PPO: See *Accidental injury*, Section 5(d) Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Oral surgery		
Removal of impacted teeth.	See *Oral and maxillofacial surgery*, Section 5(b)	See *Oral and maxillofacial surgery*, Section 5(b)
Dental benefits		
We have no other dental benefits.	All charges	All charges

Section 5(h). 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.
Round-the-clock member support	We provide integrated health benefit services including a national PPO network, clinical management services, a national transplant program, a disease management program with round-the-clock benefits support, pharmacy network and Plan administration. You can call us toll-free at any time, day or night, to: • Initiate the precertification or preauthorization process • Get assistance in locating network providers • Obtain general health care information • Have your questions about health care issues answered This 24/7 service is a benefit to you, allowing you to be informed about your health care options. There is no penalty for not using it. 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.
Health Risk Assessment	A free Health Risk Assessment is available online at www.mhbp.com. Take an important first step toward improving your awareness of lifestyle behaviors and their effects on overall health risks. You will be provided with a Personal Health Report that's automatically generated when the Assessment is completed. You may complete the Assessment every 6 months so you can track your progress and improvement.
Disease Management Program	Disease management is a voluntary program designed to help you manage a chronic condition successfully with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. Examples of illnesses that may be managed through this program are diabetes, asthma and high-risk pregnancies. A case manager will work closely with you to provide you with educational information about your condition, treatment plan or medication support. As always, your final treatment plan will be decided between you and your physician. If you have a chronic condition and would like more information, or if you have questions about your current treatment, call us at 1-800-410-7778.
Personal Health Record	The new MHBP Personal Health Record (PHR) provides members a dashboard view of their health. Members can view, track and add personal health data and use personalized tools and health information to proactively manage their health care. Access the PHR through the secure member portal at www.mhbp.com.
ExtraCare Health Card	The ExtraCare Health Card is a value-added program through CVS Caremark that gives you a 20 percent savings on thousands of CVS/pharmacy brand health-related items, from cough and cold medicine to pain and allergy relief. The cards are different from your MHBP ID card and are mailed separately. The program is offered at no additional charge to you.

Consumer Option Benefits

This Plan offers a High-Deductible Health Plan (HDHP) called Consumer Option. The Consumer Option benefit package is described in this section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled.

Consumer Option Section 5, which describes the Consumer Option benefits, is divided into subsections. Please read *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 your Consumer Option benefits, contact us at 1-800-694-9901 or visit our Web site at www.mhbp.com.

See pages 9 - 11 for how our benefits change this year and page 147 for a benefits summary.

Section 5. Consumer Option Benefits Overview

Our Consumer Option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in the MHBP Consumer Option, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility. Your full annual HRA credit will be available on your effective date of enrollment.

With this plan, PPO Preventive care is covered in full for the listed services. As you receive other non-preventive covered medical care, you must meet the Plan's deductible before we pay Traditional medical coverage benefits. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward the deductible entirely out-of-pocket, allowing your savings to continue to grow.

The MHBP Consumer Option includes five key components: PPO preventive care; traditional medical coverage that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **PPO Preventive care**

  Consumer Option covers preventive care services such as periodic health evaluations (e.g., annual physicals), screening services (e.g., mammograms), routine well-child care, child and adult immunizations, and disease management programs. These services are covered at 100% if you use a PPO provider and are described in Section 5 *PPO Preventive care*. You do not have to meet the deductible to receive these benefits. Non-PPO preventive care is not covered.

- **Traditional medical care**

  After you have paid the Plan's deductible, we pay benefits under Traditional medical coverage described in Section 5. You pay a copayment for PPO services and 40% coinsurance for Non-PPO services.

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services, other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse benefits
  - Prescription drug benefits

- **Savings**

  Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see page 73 for more details).

  Health Savings Accounts (HSA)

  By law, health savings accounts are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, are not covered under their own, or their spouse's FSA, have not received VA benefits within the last three months, or do not have another health plan other than another high-deductible health plan. In 2011, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $70.41 per month for a Self Only enrollment or $140.83 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax-free contributions to your HSA, so long as total contributions do not exceed the limit established by law, which is $3,050 for a Self Only enrollment or $6,150 for a Self and Family enrollment. See maximum contribution information on page 74. You can use funds in your HSA to help pay your Plan deductible. You own your HSA, so the funds can go with you if you happen to change plans or employment.

  Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying medical expenses from tax-free HSA dollars or after-tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

- **Savings** *(continued)*

HSA features include:

- The administrator and custodian for your HSA is HealthEquity
- Your contributions to the HSA are tax deductible up to the limit allowed by law
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS Publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable – the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in the MHBP Consumer Option with a Health Savings Account (HSA) and start or become covered by a HCFSA (such as FSAFEDS offers – see Section 12), the MHBP Consumer Option cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

If you aren't eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will establish and administer an HRA instead. You must notify us that you are not eligible for an HSA. In 2011, we will give you an HRA credit of $845 per year for a Self Only enrollment and $1,690 for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible. Once we have established an HRA for you, you cannot change to an HSA for the remainder of the calendar year, even if your eligibility for an HSA changes.

HRA Features include:

- Your HRA is administered by the Mail Handlers Benefit Plan
- Your entire HRA credit (prorated from your effective date to the end of the plan year) is available from your effective date of enrollment
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this Plan
- Unused credits carry over from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements. See Who is eligible to enroll? in Section 12 under The Federal Flexible Spending Account Program – FSAFEDS.

- **Catastrophic protection for out-of-pocket expenses**

When you use network providers, your maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,000 for a Self Only enrollment or $10,000 for a Self and Family enrollment for services from PPO providers ($7,500 Self Only or $15,000 Self and Family for Non-PPO providers). However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowance or benefit maximum). Refer to Section 4 Your catastrophic protection out-of-pocket maximum, and Consumer Option Section 5 Traditional medical care for more details.

- **Health education resources and account management tools**

Consumer Option Section 5(i) describes the health education resources and account management tools available to help you manage your health care and your health care dollars.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) **(Provided when you are ineligible for an HSA)**
Administrator	We will establish an HSA for you. The administrator and custodian for your HSA is HealthEquity.. HealthEquity 15 W Scenic Pointe Dr, Ste 400 Draper, UT 84020	MHBP is the administrator for your HRA: Mail Handlers Benefit Plan P.O. Box 8402 London, KY 40742 1-800-694-9901
Fees	Set-up and monthly administrative fees are paid by the MHBP. Contact us for additional information.	None
Eligibility	You must: • Enroll in the MHBP Consumer Option • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long-term care coverage) • Not be enrolled in Medicare • Not be claimed as a dependent on someone else's Federal tax return • Not have received VA benefits in the last three months • Not be covered by your own, or someone else's Health Care Flexible Spending Account (HCFSA) • Complete and return all banking paperwork	You must enroll in the MHBP Consumer Option. Eligibility is determined on the first day of the month following your effective date of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in this Plan. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.).	Eligibility for the annual credit will be determined on the first day of the month and will be prorated for mid-year enrollment. The entire amount of your HRA will be available to you upon your enrollment.
• **Self Only enrollment**	For 2011, a monthly premium pass through of $70.41 will be made by this Plan directly into your HSA each month.	For 2011, your HRA annual credit is $845 (prorated for mid-year enrollment).
• **Self and Family enrollment**	For 2011, a monthly premium pass through of $140.83 will be made by this Plan directly into your HSA each month.	For 2011, your HRA annual credit is $1,690 (prorated for mid-year enrollment).

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) (Provided when you are ineligible for an HSA)
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of the Plan's premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,050 for a Self Only enrollment and $6,150 for a Self and Family enrollment. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability. You may roll over funds you have in other HSAs to this Plan's HSA (rollover funds do not affect your annual maximum contribution under this Plan). HSAs can earn tax-free interest (does not affect your annual maximum contribution). Catch-up contributions are discussed on page 77.	The full HRA credit will be available, subject to proration, on the effective date of enrollment. The HRA does not earn interest.
• **Self-only enrollment**	You may make an annual maximum contribution of up to $2,205.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an annual maximum contribution of up to $4,460.	You cannot contribute to the HRA.
Access funds	You can access your HSA by the following methods: • Debit card • Manual HSA distribution form • Automatic claims crossover	For qualified medical expenses under this Plan, you or your provider will be automatically reimbursed when claims are submitted to the MHBP Consumer Option. For expenses not covered by this Plan, such as orthodontia, you can request a reimbursement form by phone or obtain one on-line at www.mhbp.com.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) **(Provided when you are ineligible for an HSA)**
Distributions/ withdrawals		
• **Medical expenses**	You can pay the out-of-pocket medical expenses for yourself, your spouse or your dependents (even if they are not covered by this Plan) from the funds available in your HSA. See IRS Publication 502 for a complete list of eligible expenses. (http://www.irs.gov/pub/irs-pdf/p502.pdf).	The available credit in your HRA will be used to pay the out-of-pocket expenses for qualified medical expenses for individuals covered under this Plan. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS Publication 502 for a list of eligible expenses. (http://www.irs.gov/pub/irs-pdf/p502.pdf). Physician prescribed over-the-counter drugs and Medicare premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.
• **Non-medical expenses**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds.	If you are under age 65, distributions will not be made for anything other than non-reimbursed qualified medical expenses.
	When you turn age 65, distributions can be used for any reason without being subject to the 20% penalty, however they will be subject to ordinary income tax.	When you turn age 65, distributions will not be made for anything other than non-reimbursed qualified medical expenses, except that Medicare premiums are reimbursable.
• **Availability of funds**	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this Plan is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • MHBP receives record of your enrollment and sends you HSA enrollment forms to complete. • HealthEquity receives the completed paperwork back from you. After HealthEquity receives the completed paperwork from you and opens your account, you can withdraw funds for expenses incurred on or after the date the HSA was initially established.	The entire amount of your HRA will be available to you upon your enrollment in this Plan.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) (Provided when you are ineligible for an HSA)
Account owner	FEHB enrollee	MHBP
Portability	You own your HSA and can take it with you when you leave Federal employment, change health plans or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 73 for HSA eligibility.	If you retire and remain in the MHBP Consumer Option, you may continue to use and accumulate credits in your HRA. If you terminate Federal employment or change health plans, only eligible expenses incurred while covered under the MHBP Consumer Option will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If you have an HSA

- **Contributions**

All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions (if available), or you may make lump sum contributions at any time, in any amount not to exceed the annual maximum limit. If you contribute, you can claim the amount contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

Contact us at 1-800-694-9901 for more details.

- **Catch-up contributions**

If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution will be $1,000 in 2011 and beyond. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U. S. Department of the Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

If you do not have a named beneficiary, if you are married, it becomes your spouse's HSA; otherwise, it becomes part of your taxable estate.

- **Qualified expenses**

You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, physician prescribed over-the-counter drugs, LASIK surgery, and some nursing services.

When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you have enrolled in Medicare.

For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on "Forms and Publications." Note: Although physician prescribed over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

You will receive a monthly statement that shows contributions and withdrawals, and interest earned on your account. You can also review the activity on your HSA by logging in to the MHBP secure member portal available at www.mhbp.com.

- **Minimum reimbursements from your HSA**

You can request reimbursement in any amount.

If you have an HRA

- **Why an HRA is established**

If you don't qualify for an HSA when you enroll in this Plan, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

Please review the chart on pages 73-76 which details the differences between an HRA and an HSA. The major differences are:

- You cannot make contributions to an HRA
- Funds are forfeited if you leave this Plan
- An HRA does not earn interest, and
- HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by this Plan. FEHB law does not permit qualified medical expenses to include 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.

Section 5. PPO preventive care

Important things you should keep in mind about these benefits:

- Under the Consumer Option, we pay 100% for the preventive care services listed in this Section as long as you use a PPO provider. Non-PPO preventive care is not covered. For all other covered expenses, please see pages 81-113 – Traditional medical coverage.
- The Consumer Option calendar year deductible does not apply to PPO preventive care 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.

Benefits description	You pay
Preventive care, adult	
Routine physical examination – one per calendar year for members age 18 and older, limited to: • Patient history and risk assessment • Basic metabolic panel • General health panel Note: Please contact us to obtain information on the specific tests covered under this benefit.	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing
Routine screenings, including related office visits, limited to: • Mammogram for women age 35 and older: – From age 35 to 39 – one during this five year period – At age 40 and older – one every calendar year • Pap smear – one per calendar year • HPV (human papillomavirus) test – one per calendar year • 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 Note: Expenses for related anesthesia and outpatient facility services are covered under this benefit. • Blood Cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members • Chlamydial infection screening • Osteoporosis screening (bone density study) one every two consecutive calendar years for members age 50 and older • Abdominal aortic aneurysm screening – one per lifetime for men age 65 to 75	Nothing
Routine hearing exam and testing – one per calendar year	Nothing

Preventive care, adult – continued on next page

Preventive care, adult *(continued)*	**You pay**
Smoking cessation • QuitPower® smoking cessation program covers up to two quit attempts per member per calendar year, including up to four counseling sessions per quit attempt and over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. Members may enroll in the QuitPower® program by calling 1-877-784-8797.	Nothing
• Physician-prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence may also be obtained from a Network retail pharmacy or through our mail order drug program.	Nothing
Not covered: • *Routine physical checkups and related tests except those listed above* • *Routine physical checkups and related tests provided in an urgent care setting*	*All charges*
Preventive care, children	
Routine childhood immunizations recommended by the American Academy of Pediatrics for members under age 22	Nothing
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.	Nothing
Routine screenings, limited to: • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members • Body mass index testing — one per calendar year for dependent children age 2 through 21	Nothing
Routine hearing exam and testing – one per calendar year	Nothing
Retinal screening exam for low birth weight premature infants as recommended by the American Academy of Pediatrics	Nothing
Not covered: • *Routine testing not specifically listed as covered* • *Routine physical checkups and related tests provided in an urgent care setting*	*All charges*

Traditional medical coverage subject to the deductible

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.
- PPO preventive care is covered at 100% (see page 79) and is not subject to the calendar year deductible. Non-PPO preventive care is not covered.
- The deductible is $2,000 for a Self Only enrollment or $4,000 for a Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits under Traditional medical coverage. You must pay your deductible before Traditional medical coverage begins.
- Under Traditional medical coverage, you are responsible for your copayments, coinsurance and amounts in excess of the Plan's allowance for covered medical expenses.
- You are protected by an annual catastrophic maximum on out-of-pocket expenses for covered services. After your copayments, coinsurance and deductible total $5,000 for a Self Only enrollment or $10,000 for a Self and Family enrollment in any calendar year for services from PPO providers ($7,500 Self Only or $15,000 Self and Family for Non-PPO providers), you do not have to pay any more for covered services. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's benefit maximum, or, if you use Non-PPO providers, amounts in excess of the Plan's allowance).
- The Consumer Option provides coverage for both PPO and Non-PPO providers. The Non-PPO benefits are the regular benefits under the Traditional medical coverage. PPO benefits apply only when you use a PPO provider. When a PPO provider is not 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.

Benefits description	You pay
Note: The calendar year deductible applies to all benefits in this Section.	
Deductible before Traditional medical coverage begins	
The deductible applies to all benefits under Traditional medical coverage. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from PPO providers, you are responsible for paying the allowable charges until you meet the deductible.	100% of allowable charges until you meet the deductible of $2,000 for a Self Only enrollment or $4,000 for a Self and Family enrollment.
After you meet the deductible, we pay the allowable charge (less your copayment or coinsurance) until you meet the annual catastrophic out-of-pocket maximum.	PPO: After you meet the deductible, you pay the indicated copayments or coinsurance for covered services. You may choose to pay the copayments or coinsurance from your HSA, or you can pay for them out-of-pocket. If you have an HRA, we will withdraw the amount from your HRA if funds are available. Non-PPO: After you meet the deductible, you pay the indicated coinsurance based on our Plan's allowance and any difference between our allowance and the billed amount. You may choose to pay the copayments or coinsurance from your HSA, or you can pay for them out-of-pocket. If you have an HRA, we will withdraw the amount from your HRA if funds are available.

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

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 deductible is $2,000 for a Self Only enrollment or $4,000 for a Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for PPO services and for coinsurance and amounts in excess of the Plan's allowance for Non-PPO services.
- The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When a PPO provider is not 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.

Benefits description	You pay After the calendar year deductible …
Diagnostic and treatment services	
Professional services of physicians • In physician's office (this includes evaluation and management services related to chemotherapy, hemodialysis and radiation therapy) • At home • In an urgent care center • Office medical consultations • Second surgical opinions provided in a physician's office	PPO: $15 copayment per visit, including testing performed and billed in conjunction with the visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Christian Science practitioners	Same as above
Professional non-emergency services provided in a convenient care clinic (see Definitions, Section 10). For services related to an accidental injury or medical emergency, see Section 5(d).	PPO: $10 copayment per visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
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 therapies*, page 86.	PPO: Nothing Non-PPO: 40% 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, except as part of a preauthorized treatment plan that we have approved* • *Orthoptic visits and related services* • *Telephone and internet-based consultations*	*All charges*

Lab, x-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CT/CAT Scans; CTA; MRA; MRI; NC; PET Note: Preauthorization for these procedures is required when performed on an outpatient basis. Call us at 1-800-694-9901 prior to scheduling. • Ultrasound • Electrocardiogram and EEG	PPO: $15 copayment per visit Non-PPO: 40% 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.
Genetic testing Note: Preauthorization for genetic testing is required. Call us at 1-800-694-9901.	PPO: $150 copayment per occurrence Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program You can use this voluntary program for covered lab tests. 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 and bills us directly, you will not have to file any claims. To find a location near you, call 1-800-377-7220, or visit our Web site at www.mhbp.com.	Nothing Note: This benefit applies to expenses for lab tests only. Related expenses for services provided by a physician are subject to applicable copayments and coinsurance.
Not covered: • *Handling and administrative charges* • *Routine lab services except as covered under Preventive care* • *Professional fees for automated tests* • *Genetic screening (see Definitions, Section 10)* • *Venipuncture, when billed as a separate procedure along with charges for the related lab test*	*All charges*

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Anesthesia • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your admission for a normal delivery; see page 16 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 your admission for a regular delivery and 96 hours after your admission for a cesarean delivery (you do not need to precertify the normal length of stay). We will cover an extended stay for you or your baby if medically necessary, but you, your representative, your doctor, or your hospital must precertify the extended stay. See pages 15-17 for other circumstances. • 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. • The initial newborn exam is payable under this benefit. • We cover circumcision under *Surgical procedures*, Section 5(b). • We cover hospitalization (inpatient and outpatient) under Section 5(c). • 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 coinsurance and/or copayments. • Maternity benefits will be paid at the termination of pregnancy. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation. Note: IV/infusion therapy and injections for treatment of complications of pregnancy are covered under *Treatment therapies*, Section 5(a).	PPO: Nothing Non-PPO: 40% 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*

Family Planning	You pay
Voluntary family planning services, limited to: • Voluntary sterilization (see *Surgical procedures*, Section 5(b)) • Surgically implanted contraceptives (see *Surgical procedures*, Section 5(b)) • Intrauterine devices (IUDs) • Injectable contraceptive drugs (such as Depo-Provera) Note: We cover the related office visit under *Diagnostic and treatment services* (see page 82). Note: We cover oral contraceptive drugs under *Prescription drug benefits*, Section 5(f).	PPO: $15 copayment per office visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Preimplantation genetic diagnosis (PGD)* • *Genetic counseling* • *Genetic screening*	*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*, Section 5(f). 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: $15 copayment per office visit Non-PPO: 40% 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 intra-fallopian transfer (GIFT)* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or egg* • *Sperm bank collection and storage fees* • *Surrogacy (host uterus/gestational carrier)*	*All charges*
Allergy care	
Testing and treatment, including materials	PPO: $15 copayment per visit, including testing performed and billed in conjunction with the visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Allergy serum	PPO: $15 copayment Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Allergy care *(continued)*	**You pay**
Allergy injections (not including allergy serum)	PPO: $15 copayment per visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
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* • *Provocative food testing and sublingual allergy desensitization* • *Clinical ecology and environmental medicine*	*All charges*
Treatment therapies	
• 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 pages 99-101. • 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 department of a hospital, clinic or a physician's office. Pharmacy charges for chemotherapy drugs (including prescription drugs to treat the side effects of chemotherapy) are covered under *Prescription drug benefits*, Section 5(f). Note: Preauthorization is required for hyperbaric oxygen therapy. Call us at 1-800-694-9901 prior to scheduling treatment.	PPO: $15 copayment per visit for services provided in a physician's office or clinic; $25 copayment per outpatient hospital visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
• Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy (including TPN) • Respiratory therapy • Inhalation therapy • Growth hormone therapy Note: Call us at 1-800-694-9901 for details about coverage and information about dialysis, IV/infusion therapy, respiratory therapy and inhalation therapy PPO providers. Note: These therapies (excluding the related office visits) are covered under this benefit when performed on an outpatient basis. Note: Pharmacy charges for related drugs and medicines, including growth hormones, are covered under Prescription drug benefits, Section 5(f). Some drugs, including growth hormones, require preauthorization; see Specialty drugs, page 111.	PPO: $15 copayment per office, clinic or home visit; $25 copayment per outpatient hospital visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Rabies shots and related services	PPO: $15 copayment per office visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Treatment therapies – continued on next page

Treatment therapies *(continued)*	You pay
Not covered: • *Chelation therapy and related services, except as part of a preauthorized treatment plan that we have approved* • *Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered under Section 5(b)* • *Topical hyperbaric oxygen therapy* • *Prolotherapy*	*All charges*
Rehabilitative therapies	
Outpatient physical therapy, speech therapy, and occupational therapy Note: The 26-visit per person combined rehabilitative, chiropractic and alternative treatment therapies annual 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 26-visit per person benefit maximum. Note: Medically necessary outpatient physical or occupational therapy provided by a skilled nursing facility (SNF) is covered under this benefit if you are not confined in the SNF.	PPO: $15 copayment per visit and all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum
Not covered: • *All charges after the Plan has paid the 26-visit per person rehabilitative, chiropractic and alternative treatment therapies annual maximum* • *Exercise programs* • *Outpatient pulmonary rehabilitation* • *Outpatient cardiac rehabilitation programs* • *Massage therapy*	*All charges*
Hearing services (testing, treatment and supplies)	
Hearing exam and testing: • Non-routine For coverage of hearing aids, see *Orthopedic and prosthetic devices*, page 88	PPO: $15 copayment per visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
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.	PPO: All charges over $50 for one set of eyeglasses or $100 for contact lenses (including examination) Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $50 for eyeglasses and $100 for contact lenses (including examination)
Not covered: • *All charges after the Plan has paid the $50 (eyeglasses) or $100 (contact lenses) benefit maximum* • *Routine eye exams and related office visits* • *Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery* • *Eye exercises* • *Refractions* • *Radial keratotomy including laser keratotomy and other refractive surgery*	*All charges*

Foot care	You pay
We pay the professional services for routine foot care for established diabetics. We also pay for medically necessary surgeries under *Surgical procedures*, Section 5(b).	PPO: $15 copayment per office visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
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*
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 • Custom constructed braces • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices (including cochlear implants) if billed by other than a hospital. Insertion of an implanted device is covered under *Surgical procedures*, Section 5(b). Note: Call us at 1-800-694-9901 for details about coverage and information about orthopedic and prosthetic PPO providers. Note: We will only cover the cost of a standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item.	PPO: Nothing Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Hearing aids – one hearing aid per ear every five (5) calendar years	PPO: $15 copayment per visit and all charges over $500 for one hearing aid per ear Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $500 for one hearing aid per ear
Not Covered: • *Orthopedic and corrective shoes unless attached to a brace* • *Arch supports, heel pads and heel cups* • *Foot orthotics and related office visits* • *Lumbosacral supports, corsets, trusses, elastic stockings, support hose, non-custom hinged knee braces and other supportive devices* • *Compression/support sleeves, except for treatment of lymphedema and severe burns* • *Prosthetic replacements provided less than 3 years after the last one we covered unless a replacement is needed for medical reasons* • *Penile prosthetics* • *Customization or personalization beyond what is necessary for proper fitting and adjustment of the items* • *Hearing aid replacements within five years after the Plan has paid the $500 per ear hearing aid maximum, replacement batteries, service contracts*	*All charges*

Durable medical equipment (DME)	You pay
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 of durable medical equipment, at our option, including repair and adjustment, such as: • Oxygen and oxygen equipment • Dialysis equipment • Wheelchairs • Hospital beds • Ostomy supplies (including supplies purchased at a pharmacy) • Audible prescription reading devices For items that are available for purchase we will limit our benefit for the rental of durable medical equipment to an amount no greater than what we would have paid if the equipment had been purchased. For coordination of benefits purposes, when we are the secondary payor, we will limit our allowance for rental charges to the amount we would have paid for the purchase of the equipment, except when the primary payor is Medicare Part B and Medicare elects to continue renting the item. Note: Call us at 1-800-694-9901 for details about coverage and 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 HRA members who have Medicare Part B as their primary payor, diabetic supplies will be covered under this benefit. Note: See *Treatment therapies* for coverage of hyperbaric oxygen therapy. Note: We will only cover the cost of standard equipment. Coverage for specialty items such as all terrain wheelchairs is limited to the cost of the standard equipment. Note: Preauthorization is required for audible prescription reading devices. Call us at 1-800-694-9901.	PPO: Nothing Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Augmentative and alternative communication (AAC) devices	PPO: All charges after the Plan has paid $500 per device Non-PPO: All charges after the Plan has paid $500 per device

Durable medical equipment (DME) – continued on next page

Durable medical equipment *(continued)*	**You pay**
Not covered: • *Equipment replacements provided less than 3 years after the last one we covered* • *Charges for service contracts for purchased or rented equipment, except for purchased oxygen concentrators* • *Safety, hygiene, convenience and exercise equipment; bedside commodes* • *Household or vehicle modifications including seat, chair or van lifts; car seats; computer switchboard* • *Air conditioners, air purifiers, humidifiers, ultraviolet lighting (except for the treatment of psoriasis), heating pads, hot/cold packs, sun or heat lamps* • *Wigs or hair pieces* • *Motorized scooters (see Definitions, Section 10), 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 or charges in excess of the secondary payor amount when we are the secondary payor except as noted on page 89* • *Customization or personalization of equipment* • *Blood pressure monitors* • *Enuresis alarms* • *Breast pumps* • *All charges for AAC devices after the Plan has paid $500 per device*	*All charges*
Home health services – (nursing services)	
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 the services are needed; and • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services. Note: Benefits are limited to 3 visits per person per calendar year Note: Services of a Christian Science Nurse are covered under this benefit.	PPO: $15 copayment per visit; all charges after 3 visits Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after 3 visits
Not covered: • *Inpatient private duty nursing* • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services and supplies primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *All charges after 3 visits per person per calendar year*	*All charges*

Chiropractic	You pay
Chiropractic care • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: The 26-visit per person combined rehabilitative, chiropractic and alternative treatment therapies annual maximum includes all covered services and supplies billed for these therapies.	PPO: $15 copayment per visit and all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum
Alternative treatment	
Acupuncture Note: The 26-visit per person combined rehabilitative, chiropractic and alternative treatment therapies annual maximum includes all covered services and supplies billed for these therapies.	PPO: $15 copayment per visit and all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum
Not covered: • *Naturopathic and homeopathic services* • *Chelation therapy and related services, except as part of a preauthorized treatment plan that we have approved* • *Thermography, biofeedback and related visits* • *Massage therapy, acupressure, hypnotherapy* • *Self care or home management training or programs* • *All charges after the Plan has paid the 26-visit per person combined rehabilitative, chiropractic and alternative treatment therapies annual maximum* *Note: Services of certain alternative treatment providers may be covered in medically underserved areas – see page 13.*	*All charges*

Educational classes and programs	You pay
QuitPower® smoking cessation program covers up to two quit attempts per member per calendar year, including up to four counseling sessions per quit attempt and over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. See *Preventive care, adult*, page 80 for more details.	Nothing (No deductible)
Diabetic education provided by a physician for members with an established diagnosis of diabetes, including: • Educational supplies • Patient instruction • Medical nutrition therapy Note: Please contact us to obtain information on the specific services covered under this benefit.	PPO: Nothing Non-PPO: All charges
Not covered: • *Self help or self management programs except diabetic education described above* • *Charges for educational/instructional advice on how to use durable medical equipment* • *Programs for nocturnal enuresis*	*All charges*

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

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 deductible is $2,000 for a Self Only enrollment or $4,000 for a Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for PPO services and for coinsurance and amounts in excess of the Plan's allowance for Non-PPO services.
- The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When a PPO provider is not available, Non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- PLEASE REMEMBER THAT ANY SURGICAL SERVICES THAT REQUIRE AN INPATIENT ADMISSION MUST BE PRECERTIFIED. Please refer to the precertification information shown in Section 3.

Benefits description	You pay After the calendar year deductible …
Surgical procedures	
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 • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices (see *Orthopedic and prosthetic devices*, Section 5(a) for device coverage information) • Voluntary sterilization • Surgically implanted contraceptives and intrauterine devices (IUDs) • Treatment of severe burns • Correction of amblyopia & strabismus Note: Preauthorization is required for all spinal surgeries. Call us at 1-800-694-9901.	PPO: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-PPO: 40% 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**
• Surgical treatment of morbid obesity – a diagnosed condition in which the body mass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction – when: – Morbid obesity has persisted for at least 3 years – There is no treatable metabolic cause for the obesity – Member has participated in a 3-month physician-supervised weight loss program that included dietary therapy, physical activity and behavior therapy within the past 6 months and has failed to lose weight – A psychological evaluation has been completed and member has been recommended for bariatric surgery – Member is age 18 or older Call us at 1-800-694-9901 for additional information about surgical treatment of morbid obesity. Note: Coverage is limited to one surgical treatment for morbid obesity per member per lifetime. Note: Preauthorization for surgical treatment of morbid obesity is required. Call us at 1-800-694-9901.	PPO: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: – PPO: the Plan's full allowance, or – Non-PPO: the Plan's full allowance • For the secondary procedure and any other subsequent procedures: – PPO: one-half of the Plan's allowance, unless the PPO contract provides for a different amount, or – Non-PPO: one-half of the Plan's allowance	PPO: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Co-surgeons When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 62.5% of what it would pay a single surgeon for the same procedure(s), unless the PPO contract provides for a different amount.	PPO: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Assistant surgeons Assistant surgical services provided by a qualified surgeon (M.D.) when medically necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan's allowance for the assistant surgeon is 16% of the allowance for the surgery, unless the PPO contract provides for a different amount.	PPO: Nothing Non-PPO: 40% 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**
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 under Reconstructive surgery)* • *Radial keratotomy, laser and other refractive surgery* • *Assistant surgeon services from a non-physician provider, such as a Physician Assistant (P.A.), Certified Registered Nurse First Assistant (C.R.N.F.A.) and a Certified Surgical Technologist (C.S.T.)*	*All charges*
Reconstructive surgery	
• 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 of breasts – Treatment of any physical complications, such as lymphedemas (see *Orthopedic and prosthetic devices*, Section 5(a) 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 for up to 48 hours after your admission.	PPO: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-PPO: 40% 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 change in bodily form, except repair of accidental injury or caused by illness* • *Surgery related to sex transformations or sexual dysfunction* • *Charges for photographs to document physical conditions*	*All charges*

Oral and maxillofacial surgery	You pay
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: Nothing for physician services performed inpatient or outpatient hospital/ASC; $15 copayment when performed in a physician's office Non-PPO: 40% 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* • *Conservative treatment of temporomandibular joint dysfunction (TMJ)* • *Dental/oral surgical splints and stents* • *Orthodontic treatment*	*All charges*

Organ/tissue transplants

Prior Authorization

All transplant procedures and transplant-related services, except corneal transplants, are subject to medical necessity and experimental/investigational review, and must be preauthorized. You, your representative, the doctor, or the hospital must contact us before your evaluation as a potential candidate for a transplant procedure so we can arrange to review the evaluation results and determine whether the proposed procedure is approved for coverage. You must have our written approval for the procedure before the Plan will cover any transplant-related expenses.

Coventry Transplant Network

- The Plan participates in the Coventry Transplant Network. Because transplantation is a highly specialized area, not all PPO hospitals are part of the Coventry Transplant Network.
- **To qualify for this program, you, your representative, the doctor, or the hospital must call us at 1-800-694-9901 as soon as the possibility of a transplant is discussed**. When you call, you will be given information about the program and participating facilities.
- To receive the Coventry Transplant Network level of benefits, you must choose a Coventry Transplant Network facility, and all transplant-related services must be received at that facility.
- All transplant admissions must be precertified.
- To use the Coventry Transplant Network, this must be your primary plan for payment of benefits.
- **Travel Benefit** – for patients using the Coventry Transplant Network the Plan may approve reasonable travel, lodging and meal expenses (if the recipient lives more than 50 miles one-way 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 1-800-694-9901 before scheduling your pre-transplant evaluation.

Donor Coverage –

- We cover donor screening and search expenses for up to four (4) candidate donors per transplant occurrence.
- We cover related medical and hospital expenses of the donor for the initial transplant confinement when we cover the recipient if these expenses are not covered under any other health plan.

Benefit Limitations

- The maximum benefit for any organ/tissue transplant(s) is:
  - Coventry Transplant Network: $1,000,000 per occurrence, which includes the following transplant-related expenses: pre-transplant evaluation, inpatient and outpatient hospital care, professional fees, postoperative follow-up care and donor expenses. To use the Coventry Transplant Network, this must be your primary plan for payment of benefits.
  - PPO and Non-PPO: $200,000 per occurrence for PPO services or $100,000 per occurrence for Non-PPO services. These benefit maximums include:

    Solid organ transplants: all transplant-related expenses from the date of the transplant procedure until the date of discharge from the hospital following the procedure.

    Autologous blood or marrow stem cell transplants: all inpatient and outpatient transplant-related services from the date of mobilization of stem cells to three months after the date of cell infusion.

    Allogeneic blood or marrow stem cell transplants: all inpatient and outpatient transplant-related services from the date of pre-transplant high-dose ablation chemotherapy to three months after the date of cell infusion.
- 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. See Section 5(c) for coverage of transplant-related services provided by a hospital.

Note: Benefits will be paid at the PPO or Non-PPO level of benefits if no Coventry Transplant Network provider is available.

Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support, is covered only for the specific diagnoses listed.

Note: Donor Leukocyte Infusion (DLI, sometimes referred to as a "boost" to a past bone marrow transplant) is covered under Section 5(a) and Section 5(c).

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You pay
Solid organ transplants, limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Liver/kidney • Pancreas* • Kidney/Pancreas • Lung: single, double, lobar • Intestinal transplants: – small intestine – small intestine with the liver – small intestine with multiple organs such as the liver, stomach, and pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis Note: Corneal transplants are not part of the Coventry Transplant Network. Benefits will be paid as described on page 93. *Note: Pancreas (only) transplants are covered for insulin dependent (or Type 1) diabetes mellitus when exogenous treatment with insulin is deemed ineffective by the Plan.	Coventry Transplant Network: Nothing for inpatient services; and all charges over $1,000,000 PPO: Nothing for inpatient services; and all charges over $200,000 Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You pay
Blood or marrow stem cell transplants, limited to the indicated stages of the following diagnoses (the medical necessity limitation is considered satisfied if the patient meets the staging description): • Allogeneic (donor) transplants for: – chronic or acute myelogenous leukemia – acute lymphocytic leukemia – acute myeloid leukemia – chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – severe or very severe aplastic anemia – severe combined immuno-deficiency disease – phagocytic/hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) – advanced Hodgkin's lymphoma – advanced non-Hodgkin's lymphomas – hemoglobinopathy (i.e., Fanconi's syndrome, thalassemia major) – myelodysplasia/myelodysplastic syndromes – amyloidosis – paroxysmal nocturnal hemoglobinuria – infantile malignant osteopetrosis – advanced neuroblastoma – Kostmann's syndrome – leukocyte adhesion deficiencies – mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) – mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) – myeloproliferative disorders (MPDs) – sickle cell anemia • Autologous (self) bone marrow transplants (autologous stem cell and peripheral stem cell support) for: – acute myelogenous leukemia – chronic or acute lymphocytic leukemia – advanced Hodgkin's lymphoma – advanced non-Hodgkin's lymphomas – advanced neuroblastoma – testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors – multiple myeloma – amyloidosis • Autologous tandem bone marrow transplants for: – multiple myeloma – de novo myeloma – recurrent testicular and other germ cell tumors	Coventry Transplant Network: Nothing for inpatient services; and all charges over $1,000,000 PPO: Nothing for inpatient services; and all charges over $200,000 Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	You pay
Blood or marrow stem cell transplants in randomized and controlled Phase III clinical trials that are sponsored by the National Cancer Institute (NCI) or the National Institutes of Health (NIH), limited to: • Allogeneic (donor) transplants for: – early stage (indolent or non-advanced) small cell lymphocytic lymphoma – multiple myeloma – advanced myelodysplastic syndromes (e.g, DeNovo, secondary, high dose) not previously treated – myelodysplasia/myelodysplastic syndromes – chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – chronic myelogenous leukemia – chronic and juvenile myelomonocytic leukemia – multiple sclerosis – hemoglobinopathies • Nonmyeloablative allogeneic transplants or Reduced intensity conditioning (RIC) for: – acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – advanced forms of myelodysplastic syndromes – advanced Hodgkins lymphoma – advanced non-Hodgkins lymphoma – breast cancer – chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – chronic myelogenous leukemia – colon cancer – early stage (indolent or non-advanced) small cell lymphocytic lymphoma – multiple myeloma – multiple sclerosis – myeloproliferative disorders – myelodysplasia/myelodysplastic syndromes – non-small cell lung cancer – ovarian cancer – prostate cancer – renal cell carcinoma – sarcomas – pediatric sickle cell disease	Coventry Transplant Network: Nothing for inpatient services; and all charges over $1,000,000 PPO: Nothing for inpatient services; and all charges over $200,000 Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000

Organ/tissue transplants – continued on next page

Organ/tissue transplants *(continued)*	**You pay**
Blood or marrow stem cell transplants in randomized and controlled Phase III clinical trials that are sponsored by the National Cancer Institute (NCI) or the National Institutes of Health (NIH), limited to: • Autologous transplants for: – chronic myelogenous leukemia – chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) – early stage (indolent or non-advanced) small cell lymphocytic lymphoma – small cell lung cancer – breast cancer – epithelial ovarian cancer – multiple sclerosis – systemic lupus erythematosis – systemic sclerosis – amyloidosis (single) – scleroderma – scleroderma-SSc (severe, progressive)	Coventry Transplant Network: Nothing for inpatient services; and all charges over $1,000,000 PPO: Nothing for inpatient services; and all charges over $200,000 Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000
Not covered: • *Expenses for services or supplies specifically excluded by the Plan, unless part of a treatment plan approved through the Coventry Transplant Network* • *Donor screening and search expenses after four screened donors, except when approved through the Coventry Transplant Network* • *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*
Anesthesia	
Professional services for the administration of anesthesia in hospital and out of hospital	PPO: Nothing for services performed on an inpatient basis or outpatient hospital /ASC; $15 copayment when performed in a physician's office Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount Note: If you use a PPO facility, we pay PPO benefits when you receive services from an anesthesiologist who is not a PPO provider. See *Preferred Provider Organization*, Section 1, for further details.

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

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 deductible is $2,000 for a Self Only enrollment or $4,000 for a Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for PPO services and for coinsurance and amounts in excess of the Plan's allowance for Non-PPO services.
- The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When a PPO provider is not 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 Section 5(a) or Section 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.

Benefits description	You pay After the calendar year deductible …
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations, including birthing centers • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, our benefit will be based on the hospital's average charge for semiprivate accommodations. Note: Hospitals billing an all-inclusive rate will be prorated between room and board and ancillary charges.	Coventry Transplant Network: Nothing PPO: Nothing Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Inpatient hospital – continued on next page

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies (ancillary services), such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic tests, such as X-rays, laboratory and pathology services, MRIs, and CAT Scans • 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, we pay under Section 5(b). Note: The maximum benefit for any organ/tissue transplant(s) as described on page 97 is: • Coventry Transplant Network: $1,000,000 per occurrence. To use the Coventry Transplant Network, this must be your primary plan for payment of benefits. • PPO and Non-PPO: $200,000 per occurrence for PPO services or $100,000 per occurrence for Non-PPO services. 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. See Section 5(b) for transplant-related professional services. Note: To use the Coventry Transplant Network, this must be your primary plan for payment of benefits. Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support is covered only for the specific diagnoses listed on pages 99-101. 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. Note: Benefits for admission to Christian Science nursing facilities are limited to $30,000 per person per calendar year.	Coventry Transplant Network: $75 copayment per day, up to a maximum of $750 per admission PPO: $75 copayment per day, up to a maximum of $750 per admission Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Inpatient hospital benefits — continued on next page

Inpatient hospital *(continued)*	**You pay**
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 after the Plan has paid $30,000 for services provided by a Christian Science nursing facility*	*All charges*
Outpatient hospital, freestanding ambulatory surgical center or clinic	
Services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic tests, such as X-rays, laboratory and pathology services, MRIs, and CAT Scans • Blood and blood plasma, if not donated or replaced, and other biologicals, including administration • 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. We do not cover the dental procedures. Note: If the stay is greater than 23 hours and you are admitted, you need to precertify the admission. Note: For services billed by a surgeon or anesthetist, see Section 5(b). For services related to an accidental injury or medical emergency, see Section 5(d).	PPO: $25 copayment per occurrence for non-surgical related services; $150 copayment per occurrence for outpatient surgery Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: *Surgical facility charges billed by entities that are not accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association for Ambulatory Health Care (AAAHC), or which do not have Medicare certification as an ASC facility.*	*All charges*

Extended care benefits/Skilled nursing care facility benefits	You pay
No benefit	*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: $25 copayment per outpatient visit; $75 per day up to a maximum of $750 per admission for inpatient services; all charges after the Plan has paid $5,000 Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid $5,000
Not covered: • *Independent nursing, and homemaker services* • *All charges after the Plan has paid $5,000*	*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. Services must be related to a covered inpatient hospitalization, a medical emergency, or associated with covered hospice care. 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. Note: Benefits for air or ground ambulance transportation that is not to the nearest hospital where appropriate treatment is available will be prorated based on mileage to the nearest hospital where appropriate treatment is available.	PPO: Nothing Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Transportation to other than a hospital, hospice or urgent care medical facility* • *Wheelchair van service; gurney van service*	*All charges*

Section 5(d). Emergency services/accidents

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.
- These benefits are payable instead of any other benefits under this Plan for emergency treatment of accidental injuries and medical emergencies.
- The deductible is $2,000 for a Self Only enrollment or $4,000 for a Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for PPO services and for coinsurance and amounts in excess of the Plan's allowance for Non-PPO services.
- The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When a PPO provider is not 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.

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.

What is a medical emergency? A medical emergency is the sudden and unexpected onset of a condition requiring immediate medical care. The severity of the condition, as revealed by the doctor's diagnosis, must be such as would normally require emergency care. Medical emergencies include heart attacks, cardiovascular accidents, loss of consciousness or respiration, convulsions and such other acute conditions as may be determined by the Plan to be medical emergencies.

Benefits description	You pay After the calendar year deductible …
Accidental injury/Medical emergency	
If you receive outpatient care for your accidental injury or medical emergency in a hospital emergency room or urgent care center, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery and related services 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: $50 copayment per occurrence (if admitted to the hospital, copayment is waived) Non-PPO: $50 copayment per occurrence and any difference between our allowance and the billed amount (if admitted to the hospital, copayment is waived)
Non-surgical physician services provided in a doctor's office for your accidental injury or medical emergency.	PPO: $15 copayment per visit Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Ambulance	You pay
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. Services must be related to a covered inpatient hospitalization, a medical emergency, or associated with covered hospice care. 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. Note: Benefits for air or ground ambulance transportation that is not to the nearest hospital where appropriate treatment is available will be prorated based on mileage to the nearest hospital where appropriate treatment is available.	PPO: Nothing Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Transportation to other than a hospital, hospice or urgent care medical facility* • *Wheelchair van service; gurney van service*	*All charges*

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

Your cost-sharing responsibilities for mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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.
- These benefits are payable instead of any other benefits under this Plan for services related to treatment of mental health/substance abuse.
- The deductible is $2,000 for a Self Only enrollment or $4,000 for a Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for In-Network services and for coinsurance and amounts in excess of the Plan's allowance for Out-of-Network services.
- The Non-Network benefits are the regular benefits of this Plan. In-Network benefits apply only when you use a Network provider. When a Network provider is not available, Out-of-Network 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.
- 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.

Benefits description	You pay After the calendar year deductible …
Professional services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
Diagnostic and treatment services: • Outpatient professional services, including individual or group therapy. This may include services provided by a Licensed Professional Counselor or Licensed Marital Family Therapist. • Medication management	In-Network: $15 copayment per visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
• Inpatient professional services	In-Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Diagnostics	
Outpatient lab, X-ray and other diagnostic tests, including psychological testing	In-Network: $15 copayment per visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Diagnostics – continued on next page

Inpatient hospital	You pay
Inpatient hospital: • 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	In-Network: $75 copayment per day, up to a maximum of $750 per admission Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Outpatient hospital	
• Electroshock therapy Note: Preauthorization for these services is required. Call us at 1-800-694-9901 prior to scheduling.	In-Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Benefits for surgical treatment of mental health/substance abuse conditions are available only for Vagus Nerve Stimulation therapy (VNS) when preauthorized as part of a treatment plan that we approve. For services billed by a surgeon or anesthetist, see Section 5(b). For services provided by the outpatient department of a hospital or ambulatory surgical center, see Section 5(c).

Not covered	
• *Services that, in the Plan's judgment, are not medically necessary* • *Services provided by Non-Network pastoral, marital, drug/alcohol and other counselors* • *Treatment for learning disabilities and mental retardation* • *Services rendered or billed by schools* • *Services provided by Non-Network residential treatment centers or halfway houses or members of their staffs*	*All charges*

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 112.
- 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 deductible is $2,000 for a Self Only enrollment or $4,000 for a Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Prescription drug benefits are available only when you obtain your covered medications from a Network retail pharmacy or the Mail order drug program.
- YOU MUST GET PREAUTHORIZATION FOR CERTAIN 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.

There are important features about your prescription drug program 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 can you obtain them?** You may fill the prescription at a network pharmacy ("network" or "network pharmacy") or by mail for certain drugs. Benefits are not available when you use a non-network pharmacy.

  Network pharmacy – Present your Plan identification card at a 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 us at 1-800-694-9901 or check the electronic directory via www.mhbp.com to locate the nearest network pharmacy.

  Non-network pharmacy – Not covered, except for prescriptions provided by Veterans Administration (VA), Department of Defense (DoD), and Indian Health Service (IHS) facilities.

  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 us at 1-800-694-9901 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 is updated periodically and 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.

  Occasionally, drugs may change from one category to another category during the year; this can affect your copayment amount. We will attempt to notify you when this occurs.

  Please note: Information about the program and a copy of the formulary was included with your identification card. When you need a prescription, share the formulary with your provider and request a Generic or Preferred category drug if possible. By choosing Generic or Preferred category drugs, you may decrease your out-of-pocket expenses. While all FDA-approved drugs are included on the formulary, we may have restrictions on certain drugs, including but not limited to, quantity limits, age limits, dosage limits and preauthorization. To request a copy of our current formulary, call us at 1-800-694-9901 or visit our Web site, www.mhbp.com.

- **Maintenance and long-term medications.** A long-term maintenance medication is one that is taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma, diabetes or high cholesterol. We have an optional program that allows members to get up to 90-day refills at a CVS retail pharmacy for the same cost-sharing as mail order. Under the program, you may choose to get the initial prescription and two refills (up to a 30-day supply) at a network retail pharmacy or a non-network retail pharmacy, or through our mail order drug program in up to a 90-day supply. After the second refill at a retail pharmacy, additional refills must be obtained either from a CVS retail pharmacy or through our mail order drug program. You will receive a letter after your second fill that describes your benefits and provides instructions on how to obtain additional refills in up to a 90-day supply. You may choose **not** to participate in this program by calling CVS Caremark at 1-866-623-1441. If you exceed three fills at a network retail pharmacy and have not advised us that you do not want to participate in this program, you may experience a delay in receiving your medication until you contact us.

Prescription drug benefits – continued on next page

Section 5(f). Prescription drug benefits *(continued)*

- **Generic drug incentive program.** You may be eligible for this program if you are currently taking a non-generic medication and switch to a generic replacement for that drug. If you qualify, you can receive up to a 90-day supply of the generic drug a no cost to you. You must obtain the generic replacement at a network retail pharmacy (for up to three 30-day refills), or through our mail order drug program (for one 90-day refill). To find out if you qualify for this program, call CVS Caremark at 1-866-623-1441.
- **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 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.
- **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 diagnoses. Since the prescription does not usually explain the reason your provider prescribed a medication, we may implement any of these limits and/or require preauthorization to confirm the intent of the prescriber.
- **Specialty drugs**, including biotech drugs, require special handling and close monitoring and are used to treat chronic complex conditions including, but not limited to: hemophilia, immune deficiency, growth hormone deficiencies, multiple sclerosis, Crohn's disease, hepatitis C, HIV, hormonal disorders, rheumatoid arthritis and pulmonary disorders. **These drugs require preauthorization to determine medical necessity and appropriate utilization**. **Specialty drugs must be obtained from CVS Caremark Specialty Pharmacy.** In addition to specialty drugs, we require preauthorization for certain classes of drugs, including, but not limited to: growth hormones; replacement enzymes; physical adjuncts; immunomodulators; drugs used to treat Attention Deficit Disorder and narcolepsy; oncologic agents; endothelin receptor antagonists; neuromuscular blocking agents; and monoclonal antibodies to IGE. **Call us at 1-800-694-9901 if you have any questions regarding preauthorization, quantity limits, or other issues**.
- We can accommodate your drug refill requests when you are called to active military duty or in the case of a declared emergency. You can call us while you are in the pharmacy or in advance at 1-800-694-9901 to request the accommodation.
- **The Plan conducts Drug Utilization Review (DUR).** 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 CVS/Caremark 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. In addition, 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. For more information about this program, call us at 1-800-694-9901.
- **When you have to file a claim.** If you purchase prescriptions at a network pharmacy and your forget your ID card or the pharmacy is unable to file your claim electronically, mail your prescription receipts to: CVS/Caremark, Attn: Claims Department, P.O. Box 52196, Phoenix, AZ 85072-2196 . Receipts must include the prescription number, name of drug, date, prescribing doctor's name, charge, name and address of drugstore and NDC number (included on the bill).

Benefits for all prescription drugs will be determined based on the fill date for the prescription.

Note: All drugs may not be available through the mail order program. Some of the drug classes that may not be 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 1-800-694-9901.

Prescription drug benefits begin on the next page

Benefits description	You pay After the calendar year deductible …
Covered medications and supplies	
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 • Oral contraceptives (Implants and implant insertions are covered under *Surgical procedures*, Section 5(b)) • Diaphragms For questions about the prescription drug program, or to obtain a copy of our current formulary, please call 1-800-694-9901 or visit our Web site at www.mhbp.com. Note: Physician-prescribed over-the-counter or prescription drugs approved by the FDA to treat tobacco dependence are covered under *Preventive care, adult*, page 80. *Note: For long-term maintenance medications, we have an optional maintenance drug management program that allows members to get up to 90-day refills at a CVS retail pharmacy for the same cost-sharing as mail order. Under the program, you may choose to get the initial prescription and two refills (up to a 30-day supply) at a network retail pharmacy or a non-network retail pharmacy, or through our mail order drug program in up to a 90-day supply. After the second refill at a retail pharmacy, additional refills must be obtained either from a CVS retail pharmacy or through our mail order drug program. Members may choose **not** to participate in this program by calling CVS Caremark at 1-866-623-1441.	Network pharmacies or prescriptions filled by foreign pharmacies, up to a 30-day supply*: – Generic: $10 copayment per prescription – Preferred brand name: $25 copayment per prescription – Non-Preferred brand name: $40 copayment per prescription Non-network pharmacies: Not covered Note: Benefits for services billed by VA facilities will be paid at the Network level of benefits; benefits for services billed by DoD and IHS facilities will be paid at 60% of the Plan's allowance. Mail order drug program, up to a 90-day supply: – Generic: $20 copayment per prescription – Preferred brand name: $50 copayment per prescription – Non-Preferred brand name: $80 copayment per prescription Medicare retail and mail order: Benefits will be paid as described above
Not covered: • *Drugs and supplies for cosmetic purposes* • *Prescriptions written by a non-covered provider* • *Vitamins, nutrients and food supplements that do not require a physician's prescription, even if a physician prescribes or administers them* • *Total parenteral nutrition (TPN) products and related services* • *Nonprescription drugs and medicines* • *Anorexiants or weight loss medications* • *Erectile dysfunction drugs* • *Drugs and supplies when another insurance plan or payor provides benefits, regardless of actual payment, for these services/supplies except Medicare covered drugs and supplies (see Durable medical equipment, Section 5(a), for Medicare 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* • *Drugs for which preauthorization has been denied*	*All charges*

Section 5(g). Dental benefits

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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) dental plan, your FEHB plan will be the first/primary payor of any benefit payments and your FEDVIP plan is secondary to your FEHB plan. See Section 9 *Coordinating benefits with other coverage*.
- The deductible is $2,000 for a Self Only enrollment or $4,000 for a Self and Family enrollment. The family deductible can be satisfied by one or more family members. The deductible applies to all benefits in this section.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage for covered medical expenses, you are responsible for your copayments for PPO services and for coinsurance and amounts in excess of the Plan's allowance for Non-PPO services.
- The Non-PPO benefits are the regular benefits of this Plan. PPO benefits apply only when you use a PPO provider. When a PPO provider is not 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.

Note: We cover hospitalization for dental procedures only when a non-dental impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure. See Section 5(c) for Inpatient hospital benefits.

Benefits description	You pay After the calendar year deductible …
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. 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 services were rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	See *Accidental injury*, Section 5(d)
Oral surgery	
Removal of impacted teeth.	See *Oral and maxillofacial surgery*, Section 5(b)
Dental benefits	
We have no other dental benefits	All charges

Section 5(h). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Round-the-clock member support	We provide integrated health benefit services including a national PPO network, clinical management services, a national transplant program, a disease management program with round-the-clock benefits support, pharmacy network and Plan administration. You can call us toll-free at any time, day or night, to: • Initiate the precertification or preauthorization process • Get assistance in locating network providers • Obtain general health care information • Have your questions about health care issues answered This 24/7 service is a benefit to you, allowing you to be informed about your health care options. There is no penalty for not using it. If you have questions about any of the programs, your benefits or would like general health information, call us at 1-800-694-9901, 24 hours a day, 7 days a week.
Disease Management Program	Disease management is a voluntary program designed to help you manage a chronic condition successfully with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. Examples of illnesses that may be managed through this program are diabetes, asthma and high-risk pregnancies. A case manager will work closely with you to provide you with educational information about your condition, treatment plan or medication support. As always, your final treatment plan will be decided between you and your physician. If you have a chronic condition and would like more information, or if you have questions about your current treatment, call us at 1-800-694-9901.
Health Risk Assessment	A free Health Risk Assessment is available online at www.mhbp.com. Take an important first step toward improving your awareness of lifestyle behaviors and their effects on overall health risks. You will be provided with a Personal Health Report that's automatically generated when the Assessment is completed. You may complete the Assessment every 6 months so you can track your progress and improvement.
Personal Health Record	The new MHBP Personal Health Record (PHR) provides members a dashboard view of their health. Members can view, track and add personal health data and use personalized tools and health information to proactively manage their health care. Access the PHR through the secure member portal at www.mhbp.com.
ExtraCare Health Card	The ExtraCare Health Card is a value-added program through CVS Caremark that gives you a 20 percent savings on thousands of CVS/pharmacy brand health-related items, from cough and cold medicine to pain and allergy relief. The cards are different from your MHBP ID card and are mailed separately. The program is offered at no additional charge to you.

Section 5(i). Health education resources and account management tools

Special features	Description
Health education resources	The Mail Handlers Benefit Plan takes the health and safety of its members seriously. Visit www.mhbp.com and select Health Education for online resources which include: • Take Charge of your Health and Wellness: Link to articles covering disease prevention, nutrition and fitness, home care, safety and more • The Medical Library: Link to articles about treatment options, common symptoms and their causes and child development • Health Risk Assessment: Members can assess their overall health profile using a comprehensive evaluation tool • Patient safety information
Account management tools	For each HSA and HRA account holder, we maintain a complete claims payment history online through our web site: www.mhbp.com Your balance will also be shown on your explanation of benefits (EOB) form. You will receive an EOB each time we process a claim. If you have an **HSA,** • You will receive a monthly statement from HealthEquity outlining your transactional account balance and activity for the month. • You will receive a quarterly statement from HealthEquity outlining your investment account balance and interest earned. • You may also access your account on-line through www.mhbp.com. • Members may also contact Member Services to review account transactions and balances and where appropriate, be connected with HealthEquity to receive information on additional services, such as reporting lost or stolen cards, receiving advice on investment options or making changes to investment options. If you have an **HRA,** • Your HRA balance will be available through www.mhbp.com. • Your balance will also be shown on your EOB form.
Consumer choice information	As a member of MHBP Consumer Option, you may choose any health care provider. However, you will receive discounts when you see a PPO provider and when you use a CVS/Caremark network pharmacy. Directories are available online at www.mhbp.com.

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 catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-800-410-7778 or visit our web site at www.mhbp.com.

The MHBP Supplemental Dental and Vision Plans

Two programs are available to ALL Federal and Postal employees and annuitants eligible for FEHBP and their family members. Help plug the gaps in your FEHBP coverage with comprehensive benefits at affordable group rates. They're brought to you by the Mail Handlers Benefit Plan, but you don't have to be an MHBP member to get them. A single annual $42 Mail Handlers Benefit Plan associate membership fee makes the MHBP Supplemental Dental and Vision Plans available to you.

Enroll in either plan – or both – any time! The sooner you enroll, the sooner your coverage starts!

The MHBP Supplemental Dental Plan – the dental care benefits you need at affordable group rates

All FEHBP members are eligible for this comprehensive and flexible dental coverage at affordable group rates. Benefits increase after your first and second years of enrollment, and you don't have to wait until Open Season to enroll. From the start, you can receive benefits up to $1,000 per person every year, and $3,000 per family. With over 120,000 DentalGuard Preferred Select Network PPO locations to choose from, and the convenience of automatic claims filing, it's easy, too! So joining right now pays off.

Summary of MHBP Supplemental Dental Plan PPO Benefits*

Benefit Category (Examples)	Calendar Year Deductible	1st Year 1st – 12th month of coverage	2nd Year 13th – 24th month of coverage	3rd Year 25th month of coverage and later
Preventive Care (Exams, cleanings and bitewing x-rays)	No deductible	100%	100%	100%
Basic Services (Fillings, extractions and other x-rays)	$50 per person up to $150 per family	70%	80%	80%
Major Services (Root canals, crowns and bridges)		Benefits begin in 2nd Year	50%	50%
Orthodontics Up to $1,000 per person per lifetime for dependents up to age 18.		Benefits begin in 3rd Year	Benefits begin in 3rd Year	50%

*Non-PPO Benefits are also available and are slightly lower. Refer to certificate of insurance for details.

The MHBP Supplemental Vision Plan — For wellness care, annual exams, eyeglasses, contacts and more

Summary of MHBP Supplemental Vision Plan PPO Benefits

Benefit Category	Frequency (based on calendar year)	Copayment	Coverage from a VSP Network Doctor
Eye Care Wellness	Regular exams help protect your eyes and health		
Exam	12 months	$10	Covered in full
Prescription eyewear	You may choose either glasses or contacts		
Lenses	12 months	$10 (applies to lenses and frame)	Single vision, lined bifocal and lined trifocal lenses covered in full
Frame	24 months		Frame of your choice covered up to $120
Contact lenses	12 months	None	$120 allowance

When you use VSP's nationwide Choice network:

- Discounted rates for laser vision correction
- Access to the nation's largest network of eyecare doctors — VSP — with no claim forms required
- Out-of-network benefits too

Get all the details on both plans at www.mhbp.com, and enroll too! Or call toll-free: 1-800-254-0227.

Non-FEHB benefits available to Plan Members – continued on next page

Non-FEHB benefits available to Plan Members *(continued)*

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 catastrophic protection out-of-pocket maximums. These programs are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-800-410-7778 or visit our web site at www.mhbp.com.

HearPO is one of the largest providers of hearing health care benefits in the United States offering members a variety of hearing aids and services through a simple three step process. HearPO has had a 90% customer satisfaction rating for over a decade! As a member, you have access to:

- Lowest Price Guarantee*: Save an average of 25% off the purchase of hearing aids!
- Discounts on hearing exams, services and batteries
- Choose from a full line of hearing aids from 7 top industry-leading manufacturers
- Financing Options with up to 12-months NO INTEREST
- 60 day no risk trial period if you are not satisfied, return your hearing aids within the trial period for a 100% refund
- 1 year follow-up care which includes cleaning, adjustment and other hearing aid services
- 3-Year warranty—one of the longest you'll find anywhere—on most hearing aids, covering repairs, loss and damage**
- Over 2200 locations throughout the nation

Step 1: Call **1-888-HEARING (1-888-432-7464)** or visit www.HearPO.com, **Step 2:** Our representative will explain the HearPO process, obtain your mailing information and assist you with directly making your appointment with the hearing care provider. **Step 3:** HearPO will send an authorization packet to you and the provider prior to your appointment. This will ensure your HearPO benefit is activated. You are responsible for the total bill, less the applicable savings, at the time service is provided.

***** Competitor coupon required for verification of price and model. Limited to manufacturers offered through the HearPO program. Local provider quotes only will be matched. ** Some exclusions apply. *Limited to one-time claim for loss and damage.*

EyeMed Vision Care Program: Save up to 40% with your EyeMed Vision Care discount program. Members are eligible for discounts on exams, glasses and contact lenses at thousands of providers nationwide. Members have access to over 33,000 providers including optometrists, ophthalmologists, opticians and leading optical retailers such as: LensCrafters, Sears Optical, Target Optical, JCPenney Optical, participating Pearle Vision locations and many independents. For more information concerning the program or to locate a participating provider, visit the Plan's Web site, www.mhbp.com, or call **1-866-559-5252.**

Laser Vision Correction: EyeMed and LCA-Vision have arranged to provide this discount program to all EyeMed members through one of the largest laser networks available, the US Laser Network. Members are entitled to 15% off the retail price or 5% off the promotional price of LASIK or PRK procedures, whichever is the greater discount. Simply call **1-877-5LASER6** to begin the process.

QualSight LASIK gives you access to savings of 40% to 50% off the overall national average price for traditional LASIK eye surgery. QualSight has 800 locations nationwide and features a credentialed network of the nation's most experienced LASIK surgeons. Flexible financing options and Lifetime Assurance plans are available including interest-free financing for up to six months for qualified individuals. To locate a provider near you call 1-877-306-2010 or visit www.QualSight.com/-MHBP for more information.

GlobalFit: Healthy living benefits from GlobalFit help you get fit, lose weight and feel your best. With GlobalFit, MHBP members can enjoy convenient and affordable access to a range of healthy living options, including memberships to GlobalFit's nationwide fitness center network. Our GlobalFit benefit offers:

- Access to thousands of **fitness centers**, from respected national chains to small independent facilities, all with the lowest rates & flexible membership options
- A special low price on **NutriSystem®**, the convenient weight-loss program with delicious, pre-packaged meals and individualized phone/email counseling
- **Healthy Changes**, customized, one-on-one programs to help you quit smoking, lose weight, reduce stress, or reach any healthy living goal
- Exclusive discounts on at-home fitness equipment

For more information, visit www.globalfit.com, or call GlobalFit toll-free at **1-800-294-1500**.
Some restrictions apply. NutriSystem is a registered trademark of NutriSystem, Inc. Healthy Changes programs are administered by WellCall, Inc. .

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies 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, drugs, or 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, and covered outpatient rehabilitative therapies are covered when billed by a skilled nursing facility;
- 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 23), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 24), 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;
- Massage therapy;
- Cardiac rehabilitation;
- Pulmonary rehabilitation;
- Eyeglasses, contact lenses and hearing aids (air or bone conduction, etc.), 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;
- Treatment for learning disabilities or mental retardation;
- Travel, even if prescribed by a doctor, except as provided under the Coventry Transplant Network 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;
- Fees for missed appointments;
- Home test kits, except for covered diabetic testing supplies, and
- Services and/or supplies not listed as covered in this brochure.
- "Never Events" are errors in patient care that can and should be prevented. We will follow the policy of the Centers for Medicare and Medicaid Services (CMS). The Plan will not cover care that falls under these policies. For additional information, visit www.cms.gov, enter Never Events into SEARCH.

Section 7. Filing a claim for covered services

There are four types of claims. Three of the four types - Urgent care claims, Pre-service claims, and Concurrent review claims - usually involve access to care where you need to request and receive our advance approval to receive coverage for a particular service or supply covered under this Brochure. See Section 3 for more information on these claims/requests and Section 10 for the definitions of these three types of claims.

The fourth type - Post-service claims - is the claim for payment of benefits after services or supplies have been received.

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at 1-800-410-7778 (TTY 1-800-852-7195), or at our Web site at www.mhbp.com.

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. All claims should be completed in ink or type that is readable by an optic scanner. For claims questions and assistance, call us at 1-800-410-7778.

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of 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) form you received from any primary payor (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.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.

Medical claims

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

The Mail Handlers Benefit Plan
Medical Claims
P.O. Box 8402
London, KY 40742

How to claim benefits *(continued)*

Prescription drug claims

Claims for covered 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 CVS Caremark network pharmacy must include receipts that show the prescription number, NDC number (included on the bill), name of drug or supply, prescribing physician's name, date, charge and name and address of the pharmacy.

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

CVS Caremark
Attn: Claims Department
P.O. Box 52196
Phoenix, AZ 85072-2196

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.

Overseas (foreign) claims

Overseas providers (those outside the continental United States, Alaska and Hawaii) will be paid at the PPO level of benefits for covered services. Overseas hospitals and physicians are under no obligation to file claims for you. **You may be required to pay for the services at the time you receive them and then submit a claim to us for reimbursement.**

- Claims for overseas (foreign) services should include an English translation when possible.
- For inpatient hospital services, the exchange rate will be based on the date of admission. For all other services, 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 United States Department of Defense third party collection program.
- Canceled checks, cash register receipts, or balance due statements are not acceptable.

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service department at 1-800-410-7778. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for us to receive this information. We will decide the claim within 48 hours of (i) receiving the information, or (ii) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with a written or electronic notification within three days of oral notification.

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

Pre-service claims procedures

As indicated in Section 3, certain services require Plan approval in advance. We will notify you of our decision within 15 days after the receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

Pre-service claims procedures *(continued)*

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claim procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

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 year-end statements.

Deadline for filing your claim

Send us all 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 re-issuance of uncashed checks.

Note: You are responsible to ensure that your claims are filed in a timely manner. Check with your provider of care about their policies regarding filing of claims.

Direct Payment to hospital or provider of care

Claims 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 benefits for your claim if we do not receive the requested information within 60 days. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

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.

Authorized representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

Please 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 required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit www.mhbp.com.

Disagreements between you and HealthEquity regarding the administration of your HSA, and between you and the Plan regarding the administration of your HRA, are not subject to the disputed claims process.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

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 8402, London, KY 40742; 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. e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.
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), precertify your hospital stay or grant your request for prior approval for a service, drug, or supply; 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. In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.
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: United States Office of Personnel Management, Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3620.

The disputed claims process *(continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

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 can 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 you did not indicate that your claim was a claim for urgent care, then call us at 1-800-410-7778. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 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 has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage".

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

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

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit or the member's responsibility as determined by the primary plan, whichever is less. 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.

Please see Section 4, *Your costs for covered services*, for more information about how we pay claims.

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans, page 127.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. This notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 without cost. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage 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 managed care plan you have.

(Please refer to page 23 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

- **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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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.

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

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payor, we process the claim first.
- When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-410-7778 or see our Web site at www.mhbp.com.

We waive some costs if the Original Medicare Plan is your primary payor – 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.

Standard Option

When Original Medicare is primary, all or part of your Plan deductibles, copayments 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, inpatient mental health/substance abuse benefits and nursing 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, ambulance services and outpatient mental health/substance abuse services.

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

Standard Option, when you are enrolled in the Medicare Part B pilot program

The Plan will not waive any deductibles, copayments or coinsurance when you have Medicare Part A and/or B as your primary payor.

Value Plan

The Plan will not waive any deductibles, copayments or coinsurance when you have Medicare Part A and/or B as your primary payor.

Consumer Option

- If your physician accepts Medicare assignment, then you pay nothing if you have unused credit available under your HRA to pay the difference between the Medicare approved amount and Medicare's payment. After your HRA is exhausted and your deductible has been met, you pay either the difference between the Medicare approved amount and Medicare's payment or your copayment amount, whichever is less.

Note: The Plan will not waive any deductibles, copayments or coinsurance when you have Medicare Part A and/or B as your primary payor.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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. You may be responsible for paying the difference between the billed amount and the amount we paid. We will not waive any deductibles, coinsurance or copayments when paying these claims.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage 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 Advantage Plan, tell us. We will need to know whether you are in the Original Medicare Plan or in Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

- **Medicare Part B pilot program for Standard Option members**

We offer a voluntary pilot program for Standard Option members that is designed to help members who are enrolled in Medicare Part A to also enroll in Medicare Part B. For each month you are enrolled in the program during 2011 and have Medicare Parts A and B as your primary coverage, the Plan will contribute an amount equal to the regular 2011 Medicare Part B monthly premium of $120.20.

You may enroll in this program if you currently have Medicare Part A only as your primary coverage, but you must enroll for Medicare Part B during the next Medicare general enrollment period, January through March, 2011. Your contributions will begin when your Medicare Part B coverage begins, in July of 2011. You may also enroll in this program if you already have Medicare Parts A and B as your primary coverage. Your contributions will begin in January, 2011.

Your opportunity to voluntarily enroll or dis-enroll in the program is limited to FEHBP Open Season. If, for any reason, Medicare ceases to be your primary coverage, you will no longer be eligible to participate in the program. Your contributions will end and your regular MHBP Standard Option benefits will resume.

Program participants are responsible for the Standard Option deductibles, copayments and coinsurance in addition to the Medicare deductibles. All Plan benefits for program participants are administered in the same manner as for non-Medicare members. The Plan will not waive its deductibles, copayments, or coinsurance for pilot participants. To be eligible for reimbursement, participants must submit proof of Medicare Part B premium payment such as the NOTICE OF MEDICARE PREMIUM PAYMENT DUE accompanied by an MHBP request for reimbursement.

To learn more about the pilot program and how to enroll, call us at 1-800-410-7778. We will send you additional information and an enrollment form. You must complete and return the enrollment form in order to participate in the program.

We will evaluate the program each year to determine its continuation. If we decide to discontinue the program, we will notify you in advance.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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 (Having coverage under more than two health plans may change the order of benefits determined on this chart).

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you…	**The primary payor for the individual with Medicare is…**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB coverage through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and… • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more.	✓*	
B. When you or a covered family member…		
1) Have Medicare solely based on end stage renal disease (ESRD) and… • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and… • This Plan was the primary payor before eligibility due to ESRD (for the 30-month coordination period)		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and … • Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30-month coordination period)		✓
• Medicare based on ESRD (after the 30-month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you…		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation

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 TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) 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 you 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.

Clinical trials

If you are a participant in a clinical trial, this health plan will provide benefits for related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

When others are responsible for injuries

If you (the enrollee or any covered family member) suffer injuries in an accident or become ill because of another person's act or omission, and you later receive compensation for the injuries or illness from that person or your own or other insurance, you are required to reimburse us out of that compensation for any benefits we paid on your behalf or, if applicable, to you, your heirs, estate, administrators, successors, or assignees. This is known as our right of reimbursement, and is also sometimes referred to as subrogation.

You will have this obligation to reimburse us even if the compensation you receive is not sufficient to compensate you fully for all of the damages which resulted from the injuries or illness. In other words, we are entitled to be reimbursed for those benefit payments even if you are not "made whole" for all of your damages by the compensation you receive. Our right of reimbursement is also not subject to reduction for attorney's fees under the "common fund" doctrine without our written consent. In short, we are entitled to be reimbursed for 100% of the benefits we pay on account of the injuries or illness unless we agree in writing to accept a lesser amount.

We enforce this right of reimbursement by asserting a priority lien against any and all compensation you receive by court order or out-of-court settlement, without regard to how it is characterized, for example as "pain and suffering." You must cooperate with our enforcement of our right of reimbursement by:

- telling us promptly whenever you have filed a claim for compensation resulting from an accidental injury or illness;
- accepting our lien for the full amount of the benefits we have paid;
- agreeing to assign any proceeds from third party claims or your own insurance to us if we ask you to do so;
- keeping us advised of the claim's status;
- advising us of any settlement or court order;
- and promptly reimbursing us out of any recovery received to the full extent of our right of reimbursement.

You must also sign a Reimbursement Agreement for this purpose when asked to do so. Our right to full reimbursement applies even to benefits we paid before learning of a potential recovery, and before asking you to sign a Reimbursement Agreement; it also applies to any benefits payable on covered expenses incurred but not submitted for payment to us or processed by us before the date of a settlement or court order. Failure to cooperate with these obligations may result in the temporary suspension of your benefits and/or offsetting of future benefits.

If you would like more information about the subrogation process and how it works, please call our Third Party Recovery Services unit at 301-610-0919.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Section 10. Definitions of terms we use in this brochure

Accidental injury

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.

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.

Clinical trials cost categories

Categories for costs associated with clinical trials are:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

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 19.

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.

Convenient care clinic

A small healthcare facility, usually located in a high-traffic retail outlet, with a limited pharmacy, that provides non-emergency, basic health care services on a walk-in basis. Examples include Minute Clinic® in CVS retail stores and Take Care Clinic℠ at Walgreens. Convenient care clinics are different from Urgent care centers (See *Urgent care center*, page 135)

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 18.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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 18.

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 trial 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.

Genetic screening

The diagnosis, prognosis, management, and prevention of genetic disease for those patients who have no current evidence or manifestation of a genetic disease and those who we have not determined to have an inheritable risk of genetic disease.

Genetic testing

The diagnosis and management of genetic disease for those patients with current signs and symptoms, and for those who we have determined to have an inheritable risk of genetic disease.

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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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.

Incurred

An expense is incurred on the date a service or supply is rendered or received unless otherwise noted in this brochure.

Medical emergency

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

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.

Mental health/substance abuse

Conditions and diseases listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as psychoses, neurotic disorders or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by the Plan; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics or hallucinogens.

Morbid obesity

A diagnosed condition in which the body mass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction. Eligible members must be age 18 or older.

Orthopedic appliance

Any custom 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:

For all dialysis services the Non-PPO allowance is the maximum Medicare allowance for such services.

For other than dialysis services, the following applies:

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 called a "blended" fee schedule. Member out-of-pocket costs resulting from the application of the blended rate fee schedule will be limited to no more than an additional $5,000 (not including applicable coinsurance or copayments) beyond the out-of-pocket costs (not including applicable coinsurance or copayments) that would have been incurred if the blended rate had not been applied to the claim. This limitation on such additional out-of-pocket costs is applicable separately (per occurrence) to inpatient or outpatient hospital or ambulatory surgical center services and separately (per occurrence) to surgical fees. Other services to which the blended rate fee schedule applies are not subject to this limitation. We encourage you to call the Plan before scheduling any outpatient hospital or ambulatory surgical center services and/or surgery so that we may assist you, if possible, in avoiding situations where the blended rate fee schedule will be applied.

Note: For those members who do not have adequate access to a network provider (in terms of distance from where you receive care, or to a network provider), those members receiving emergency care, or where there is no "blended" fee schedule amount for the service or supply, the Plan's Non-PPO allowance will be based on the Plan's out-of-network (OON) fee schedule (as described below), not the "blended" fee schedule.

If you receive services from a participating provider (see *Other Participating Providers*, page 6), the Plan's allowance will be the amount that the provider has negotiated and agreed to accept for the services and or supplies. Benefits will be paid at Non-PPO benefit levels, subject to the applicable deductibles, coinsurance and copayments.

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 lesser of: (1) the provider's billed charge; or (2) the Plan's OON fee schedule amount. The Plan's OON fee schedule amount is equal to the 80th percentile amount for the charges listed in the Prevailing Healthcare Charges System or the Medicare Data Resources System administered by FAIR Health, Inc. if such a charge exists for the service or supply. If no FAIR Health charge exists, the OON fee schedule amount may be determined by using the iSight rate established by National Care Network. The OON fee schedule amounts vary by geographic area in which services are furnished.

For certain services, exceptions may exist to the use of the OON fee schedule to determine the Plan's Non-PPO allowance, including, but not limited to, the use of Medicare fee schedule amounts. For claims governed by OBRA '90 and '93, the Plan allowance will be based on Medicare allowable amounts as is required by law. For claims where the Plan is the secondary payor to Medicare (Medicare COB situations), the Plan allowance is the Medicare allowable charge.

Plan allowance *(continued)*

We apply the National Correct Coding Initiative (NCCI) edits published by the Centers for Medicare and Medicaid Services (CMS) in reviewing billed services and making Plan benefit payments for them.

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

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

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.

Routine services

Services that are not related to any specific illness, injury, set of symptoms or maternity care.

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.

Sound Natural Tooth

A tooth that has sound root structure and an intact, complete layer of enamel or has been properly restored with a material or materials approved by the ADA and has healthy bone and periodontal tissue.

Urgent care center

An ambulatory care center, outside of a hospital emergency department, that provides emergency treatment for medical conditions that are not life-threatening, but need quick attention, on a walk-in basis.

Urgent care claims

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-Service Claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service department at 1-800-410-7778. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to the Mail Handlers Benefit Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, 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;
- What happens 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. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

Children	Coverage
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married children	Married children (but NOT their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent–child relationship to be eligible for coverage up to age 26.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Foster children	Foster children are eligible for coverage up to age 26.

You can find additional information at www.opm.gov/insure.

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, 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 26 years of age or older who is incapable of self-support.

- **Types of coverage available for you and your family** *(continued)*

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after 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 benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 26 turns age 26.

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 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 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 in the Blue Cross and Blue Shield Service Plan's Basic Option.

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 cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective 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. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2011 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2010 benefits until the effective date of your coverage with your new plan. 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.

If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

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 provide health coverage for you. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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 Web site, 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 26 regardless of marital status, 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 Benefits 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.

Individual conversion policies available to former members of the Mail Handlers Benefit Plan are underwritten and administered by the Celtic Insurance Company of Chicago, IL. If you request a conversion policy, Celtic Insurance Company will send you the available policy benefits and rates applicable in your state/area of residence.

- **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 FEHB Web site at www.opm.gov/insure/health; 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 information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll**.

There are three types of FSAs offered by FSAFEDS: Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin products, physician prescribed over-the-counter medications, vision and dental expenses, and much more) for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse, if married) must be working, looking for work (income must be earned during the year), or attending school full time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337) (TTY 1-800-952-0450), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program, and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

- **It's important protection**

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

Summary of Standard Option benefits for the Mail Handlers Benefit Plan – 2011

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 calendar year medical deductible of $400 per person (PPO)/$600 per person (Non-PPO). 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.

Standard Option Benefits	You pay	Page(s)
Medical services provided by physicians		
• Diagnostic and treatment services provided in the office	PPO: • Primary care physician: $20 copayment per office visit for adults; $10 copayment per office visit for dependent children under age 22; • Specialty physician: $40 copayment per visit • Diagnostic X-rays, laboratory services and other professional services: 10%* of the Plan's allowance Non-PPO: • Primary care physician and Specialty physician: 30%* of the Plan's allowance and any difference between our allowance and the billed amount • Diagnostic X-rays, laboratory services and other professional services: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	27-28
Services provided by a hospital		
• Inpatient	PPO: $200 copayment per admission and 15% of the Plan's allowance for hospital ancillary services (No deductible) Non-PPO: $500 copayment per admission; 30% of covered charges and any difference between our allowance and the billed amount (No deductible)	53-55
• Outpatient	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	34, 55-56
Emergency benefits		
• Accidental injury	PPO: • Emergency room: $200 copayment per occurrence • Urgent care center: $50 copayment per occurrence Non-PPO: • Emergency room: $200 copayment per occurrence and any difference between our allowance and the billed amount • Urgent care center: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	58-59
• Medical emergency	PPO: • Emergency room: $200 copayment per occurrence* • Urgent care center: $50 copayment per occurrence* Non-PPO: • Emergency room: $200 copayment per occurrence* and any difference between our allowance and the billed amount • Urgent care center: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	59-60

Summary of Standard Option benefits – continued on next page

Summary of Standard Option benefits *(continued)*

Standard Option Benefits *(continued)*	You pay	Page(s)
Mental health and substance abuse treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	61-62
Prescription drugs	Network Retail electronic: • Generic: $10 copayment per prescription • Preferred brand name: 30% of the Plan's allowance, limited to $200 per prescription • Non-Preferred brand name: 50% of the Plan's allowance, limited to $200 per prescription • Specialty: $150 copayment per prescription Network Retail paper: 50% of the Plan's allowance and any difference between our allowance and the billed amount Non-Network Retail: 50% of the Plan's allowance and any difference between our allowance and the billed amount Mail Order: • Generic: $15 copayment per prescription • Preferred brand name: $80 copayment per prescription • Non-Preferred brand name: $120 copayment per prescription • Specialty: $400 copayment per prescription	63-66
Dental care	Accidental injury; Oral surgery	67
Special features: Flexible Benefits Option; Round-the-clock Member Support; Health Risk Assessment; Disease Management Program; Personal Health Record		68
Protection against catastrophic costs (out-of-pocket maximum) There is a separate out-of-pocket maximum for Specialty drugs obtained from a Network pharmacy or through our Mail Order program. This benefit does not apply to Specialty drugs obtained from any other source.	Nothing after your covered expenses total $6,000 per calendar 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 $10,000. Some costs do not count toward this protection	20-21

Summary of Value Plan benefits for the Mail Handlers Benefit Plan – 2011

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 calendar year medical deductible of $600 per person (PPO)/$900 per person (Non-PPO). 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.

Value Plan Benefits	You pay	Page(s)
Medical services provided by physicians		
• Diagnostic and treatment services provided in the office	PPO: • Primary care physician: $30 copayment per office visit • Specialty physician: $50 copayment per office visit* • Diagnostic X-rays, laboratory services and other professional services: 20%* of the Plan's allowance Non-PPO: • Primary care physician and Specialty physician: 40%* of the Plan's allowance and any difference between our allowance and the billed amount • Diagnostic X-rays, laboratory services and other professional services: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	27-28
Services provided by a hospital		
• Inpatient	PPO: 20%* of the Plan's allowance for covered hospital services Non-PPO: 40%* of the Plan's allowance for covered charges and any difference between our allowance and the billed amount	53-55
• Outpatient (Non-Surgical)	PPO: 20%* of the Plan's allowance Non-PPO: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	34, 56
• Outpatient (Surgical)	PPO: $300 copayment per occurrence Non-PPO: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	55
Emergency benefits		
• Accidental injury/Medical emergency	PPO: • Emergency room: 20%* of the Plan's allowance • Urgent care center: 20%* of the Plan's allowance and any difference between our allowance and the billed amount Non-PPO: • Emergency room: 20%* of the Plan's allowance and any difference between our allowance and the billed amount • Urgent care center: : 40%* of the Plan's allowance and any difference between our allowance and the billed amount	58-60
Mental health and substance abuse treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	61-62

Summary of Value Plan benefits – continued on next page

Summary of Value Plan benefits *(continued)*

Value Plan Benefits *(continued)*	You pay	Page(s)
Prescription drugs	Network Retail electronic: • Generic: $10 copayment per prescription • Preferred brand name, Non-Preferred brand name and Specialty: 50% of the Plan's allowance and any difference between our allowance and the billed amount Network Retail paper: All charges Non-Network Retail: All charges Mail Order: • Generic: $30 copayment per prescription • Preferred brand name, Non-Preferred brand name and Specialty: 50% of the Plan's allowance and any difference between our allowance and the billed amount	63-66
Dental care	Accidental injury; Oral surgery	67
Special features: Flexible Benefits Option; Round-the-clock Member Support; Health Risk Assessment; Disease Management Program; Personal Health Record		68
Protection against catastrophic costs (out-of-pocket maximum) There is a separate out-of-pocket maximum for prescription drugs obtained from a Network pharmacy or through our Mail Order program. This benefit does not apply to drugs obtained from any other source.	Nothing after your covered expenses total $7,000 per calendar 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 $10,000. Some costs do not count toward this protection.	20-21

Summary of Consumer Option benefits for the Mail Handlers Benefit Plan – 2011

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.

In 2011, for each month you are eligible for the HSA, the Plan will deposit $70.41 per month for a Self Only enrollment or $140.83 per month for a Self and Family enrollment to your HSA. If you are not eligible for an HSA, the Plan will establish an HRA for you.

Traditional medical coverage (other than PPO preventive care) is subject to the Consumer Option calendar year deductible of $2,000 for a Self Only enrollment or $4,000 for a Self and Family enrollment. You can choose to use the funds in your HSA to pay your deductible, or you can pay your deductible out-of-pocket. If you have an HRA, we will withdraw the amount from your HRA if funds are available. After you meet the deductible, you pay the indicated copayments or coinsurance for covered services up to the annual catastrophic protection maximum for out-of-pocket expenses. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network provider.

Consumer Option Benefits	You pay	Page(s)
PPO Preventive care (see specific services)	PPO: Nothing (No deductible) Non-PPO: All charges	79-80
Medical/surgical services provided by physicians		
• Diagnostic and treatment services provided in the office	PPO: • Physician's office services: $15 copayment per office visit • Diagnostic X-rays and laboratory services: $15 copayment per visit • Surgery, maternity and hospital visits: Nothing Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount	82-96
Services provided by a hospital		
• Inpatient	PPO: $75 copayment per day, up to maximum of $750 per admission Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount	102-104
• Outpatient (Non-Surgical)	PPO: $25 copayment per occurrence for outpatient hospital services Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount	104
• Outpatient (Surgical)	PPO: $150 copayment per occurrence for outpatient surgery Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount	104
Emergency benefits		
• Accidental injury/Medical emergency	PPO: $50 copayment per occurrence (waived if admitted) Non-PPO: $50 copayment per occurrence (waived if admitted) and any difference between our allowance and the billed amount	106-107
Mental health and substance abuse treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	108-109

Summary of Consumer Option benefits – continued on next page

Summary of Consumer Option benefits *(continued)*

Consumer Option Benefits *(continued)*	You pay	Page(s)
Prescription drugs	Network Retail electronic: • Generic: $10 copayment per prescription • Preferred brand name: $25 copayment per prescription • Non-Preferred brand name: $40 copayment per prescription Mail Order: • Generic: $20 copayment per prescription • Preferred brand name: $50 copayment per prescription • Non-Preferred brand name: $80 copayment per prescription Non-Network Retail/Mail Order: Not covered	110-112
Dental care	Accidental injury; Oral surgery	113
Special features: Flexible Benefits Option; Round the clock member support; Health Risk Assessment; Disease Management Program; Personal Health Record		114
Protection against catastrophic costs (out-of-pocket maximum)	PPO: Nothing after your covered expenses total $5,000 for a Self Only enrollment ($10,000 Self and Family) per calendar year for PPO providers/facilities Non-PPO: Nothing after your covered expenses total $7,500 for a Self Only enrollment ($15,000 Self and Family) per calendar year for Non-PPO providers/facilities Some costs do not count toward this protection.	21

2011 Rate Information for the Mail Handlers Benefit Plan

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

Postal rates apply to career Postal Service employees. Most career employees should refer to the *Guide to Federal Benefits for Career United States Postal Service Employees,* RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Value Plan Self Only	**414**	**$98.97**	**$32.99**	**$214.43**	**$71.48**	**$111.51**	**$20.45**
Value Plan Self and Family	**415**	**$235.95**	**$78.65**	**$511.22**	**$170.41**	**$265.84**	**$48.76**
Standard Option Self Only	**454**	**$180.66**	**$101.43**	**$391.43**	**$219.77**	**$203.24**	**$78.85**
Standard Option Self and Family	**455**	**$403.98**	**$241.60**	**$875.29**	**$523.47**	**$454.48**	**$191.10**
Consumer Option Self Only	**481**	**$136.65**	**$45.55**	**$296.08**	**$98.69**	**$153.96**	**$28.24**
Consumer Option Self and Family	**482**	**$309.64**	**$103.21**	**$670.88**	**$223.63**	**$348.86**	**$63.99**