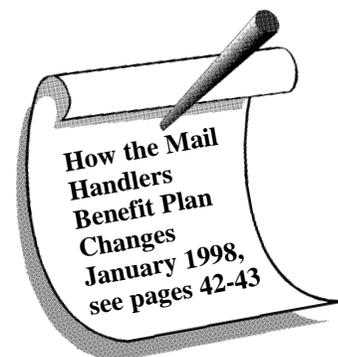




Mail Handlers Benefit Plan

1998

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



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

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

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

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

Enrollment code for this Plan:

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

Authorized for distribution by the:



United States
Office of
Personnel
Management



RI 71-7

Mail Handlers Benefit Plan

The National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO, has entered into Contract No. CS 1146 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by Continental Assurance Company which also administers this Plan on behalf of the Union, and Continental Assurance Company is referred to as Carrier in this brochure. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is based on text incorporated into the contract between OPM and the Union as of January 1, 1998, and is intended to be a complete statement of benefits available to FEHB members. It describes the benefits, exclusions, limitations, and maximums of the Mail Handlers Benefit Plan for 1998 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 1999 or later years, and does not have a right to benefits available prior to 1998 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits, or increase the amount of FEHB benefits, is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation — sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800-410-7778 and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

**THE HEALTH CARE FRAUD HOTLINE
202/418-3300**

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, DC 20415

The inappropriate use of membership identification cards, e.g. to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

When you need help with Plan benefits, or getting your ID card, call your Plan at 1-800-410-7778. The Fraud Hotline cannot help you with these.

Using This Brochure

The **Table of Contents** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers**. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid one way if it is billed by an inpatient facility and paid another way when it is billed by a doctor, physical therapist, or outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification**; generally, hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare**. And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

Authorized for distribution by the:



**United States
Office of
Personnel
Management**



1998 Rate Information for

Mail Handlers Benefit Plan

FEHB benefits of this Plan are described in brochure RI 71-7.

The 1998 rates for this Plan follow. **Non-Postal rates** apply to most non-Postal enrollees. If you are in a special enrollment category, refer to an FEHB Guide or contact the agency that maintains your health benefits enrollment. **Postal rates** apply to all USPS career employees and do not apply to non-career Postal employees, Postal retirees or associate members of any Postal employee organization.

Type of Enrollment	Code	<u>Non-Postal Premium</u>				<u>Postal Premium</u>	
		<u>Bi-Weekly</u>		<u>Monthly</u>		<u>Bi-Weekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	451	\$65.96	\$33.99	\$142.91	\$73.65	\$78.06	\$21.89
High Option Self and Family	452	\$142.27	\$68.56	\$308.25	\$148.55	\$168.36	\$42.47
Standard Option Self Only	454	\$54.77	\$18.25	\$118.66	\$39.55	\$64.81	\$8.21
Standard Option Self and Family	455	\$118.86	\$39.62	\$257.53	\$85.84	\$140.65	\$17.83

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How This Plan Works

Help Contain Costs

You can help

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

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

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with the Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by \$500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on pages 32–33 of this brochure.

Flexible benefits option

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

PPO

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

Facilities and Other Providers

Covered facilities

Hospice

A facility that:

- (1) provides primarily inpatient care to terminally ill patients;
- (2) is licensed/certified by the jurisdiction in which it operates;
- (3) is supervised by a staff of doctors (M.D. or D.O.) with at least one such doctor on call 24 hours a day;
- (4) provides 24-hour-a-day nursing services under the direction of a registered nurse (R.N.) and has a full-time administrator; and
- (5) provides an ongoing quality assurance program.

Hospital

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

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

Facilities and Other Providers *continued*

Hospital *(continued)*

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

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

- (a) is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged; or
- (b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or
- (c) is operated as a school; or
- (d) is operated as a residential treatment facility regardless of its State licensure or accreditation status.

Covered providers

For purposes of this Plan, covered providers include: 1) a licensed doctor of medicine (M.D.), or a licensed doctor of osteopathy (D.O.), hereafter referred to as a doctor; and 2) for certain specified services covered by this Plan, a licensed doctor of podiatry (D.P.M.), a licensed dentist, a chiropractor, a licensed clinical physical therapist, a licensed occupational therapist, or a licensed speech therapist. Other covered providers include qualified clinical psychologist; clinical social worker; optometrist; audiologist; acupuncturist; physician’s assistant; nurse midwife; nurse practitioner/clinical specialist; and nursing school-administered clinic. Covered providers must be appropriately licensed or certified as determined by the Carrier. For purposes of this FEHB brochure, the term “doctor” includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically- underserved areas

Within States designated as medically-underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1998, the States designated as medically underserved are: Alabama, Georgia, Louisiana, Mississippi, New Mexico, South Carolina, South Dakota, West Virginia and Wyoming.

PPO arrangements

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

PPO facilities and providers have agreed to provide services to Plan members at a lower cost than you’d usually pay for a non-PPO provider. Although PPOs are not available in all locations or for all services, when you use these providers you help contain health care costs and reduce what you pay out of pocket. The selection of PPO providers is solely the Carrier’s responsibility; PPO providers are independent contractors and final decisions about health care are the sole responsibility of the doctor and patient; however, benefit decisions made by the Carrier are dependent upon all the terms of this brochure. Continued participation of any specific provider **cannot be guaranteed.**

PPO benefits apply only when you use a PPO provider. If no PPO provider is available, or you do not use a PPO provider, the regular non-PPO benefits apply. (If you receive non-covered services from a PPO provider, the PPO discount will not apply and these services will be excluded from coverage.)

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

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

Facilities and Other Providers *continued*

This Plan's PPO

If confinement in a PPO hospital is chosen, and precertification of hospital services is obtained, under **High Option** the inpatient hospital deductible will be waived; under **Standard Option** the inpatient hospital deductible will be \$150. If PPO doctors are chosen, the Plan will pay **100%** of the covered charges for the visit after a \$15 copayment. If a PPO provider is chosen for X-ray and machine tests, the Plan will pay **100%** of the covered charges after a \$15 copayment. If outpatient laboratories are chosen, the Plan will pay **100%** of covered charges after a \$5 copayment for each billed laboratory test. For maternity, surgical and anesthesia benefits, the Plan will pay 100% after a \$50 copayment in the High Option and 95% after a \$50 copayment in the Standard Option. PPO benefits will be paid instead of regular Plan benefits whenever you receive care from a PPO doctor or laboratory. Drugs purchased at a pharmacy are not subject to PPO benefits. Drugs supplied or administered by a PPO provider are eligible for PPO benefits. The Plan offers PPO networks in certain areas of the following states:

Alabama	Indiana	Missouri	Oregon
Arkansas	Iowa	Nebraska	Pennsylvania
Arizona	Kansas	Nevada	Rhode Island
California	Kentucky	New Hampshire	South Carolina
Colorado	Louisiana	New Jersey	Tennessee
Connecticut	Maine	New Mexico	Texas
District of Columbia	Maryland	New York	Utah
Florida	Massachusetts	North Carolina	Virginia
Georgia	Michigan	North Dakota	Washington
Illinois	Minnesota	Ohio	West Virginia
	Mississippi	Oklahoma	Wisconsin

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

The Plan will be establishing additional PPO networks. Enrollees will be notified by mail when additional PPOs become available in their areas. PPO information, including whether or not your city or town is part of a PPO network, can be obtained by calling a Customer Relations Associate at the Regional Service Center at 1-800-410-7778. Participating hospitals, doctors and laboratories are listed in directories that the Plan sends to its members. **Please remember to check on the physician's active status as a PPO provider when you telephone for an appointment.**

Cost Sharing

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible. Each family member must satisfy all applicable deductibles. Deductibles do not calculate to the catastrophic protection benefit. There is no family limit.

Calendar Year Deductible

Calendar year deductible is the amount of expense an individual must incur for covered services and supplies each calendar year before the Plan pays for certain benefits. The deductible is \$100 per person for **Standard Option**, non-PPO providers for certain services.

Outpatient surgery

There is a \$250 deductible applied to the facility charge for each outpatient surgery session for the High Option, \$300 for the Standard Option. The deductible is waived if surgery is performed in a PPO facility. And you are responsible for 30% of the costs of the surgical facility if you have your surgery in a Non-PPO facility.

Cost Sharing *continued*

Hospital admission	The hospital deductible is \$250 per medical, maternity, and mental conditions/substance abuse admission under High Option and \$300 per admission under Standard Option . If confinement is in a PPO hospital, under High Option the deductible is waived; under Standard Option the deductible is reduced to \$150.
Durable medical equipment and prosthetic devices	There is a \$100 deductible per item for durable medical equipment and prosthetic devices.
Emergency room treatment of illness	There is a \$50 deductible per visit for emergency room treatment of illness. The deductible is waived if services are performed in a PPO facility.
Prescription drugs	There is a \$250 prescription drug deductible per person per calendar year under High Option and a \$600 prescription drug deductible per person per calendar year under Standard Option for prescription drugs.
Carryover	If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible in the prior year will be covered by your old plan if they are for care you received in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible or copayment. The Plan will base this percentage on either the billed charge or the usual, reasonable and customary charges, whichever is less. You are required to pay the following coinsurance on benefits under this Plan: You pay 30% of reasonable and customary charges for inpatient mental conditions/substance abuse treatment and 50% of reasonable and customary charges for outpatient treatment of mental conditions/substance abuse. You pay 30% of reasonable and customary charges for outpatient facility charge for surgery, chemotherapy, radiation therapy, hemodialysis, machine diagnostic procedures, doctors' visits (inpatient and outpatient), surgery (inpatient and outpatient), anesthesia (except under Dental Benefits), and obstetrical care will be paid according to a reasonable and customary method except for PPO providers who are paid according to negotiated rates. You pay 25% under **High Option** and 30% under **Standard Option** of actual charges for prescription drugs purchased at a PCS network pharmacy. You pay 50% of actual charges for prescription drugs purchased at a non PCS network pharmacy. You pay 25% of reasonable and customary charges for emergency treatment for illness.

After you meet any deductible, the coinsurance is the minimum amount you will have to pay. When the Plan pays 70% of reasonable and customary charges for a covered service, you are responsible for the 30% coinsurance. In addition, you are responsible for any excess charge over the Plan's reasonable and customary allowance under most circumstances. For example, if the provider ordinarily charges \$100 for a service but the Plan's reasonable and customary allowance is \$95, the Plan will pay 70% of the allowance, which is \$66.50. You must pay the 30% coinsurance, which is \$28.50, plus the difference between the actual charges and the reasonable and customary allowance, which is \$5, for a total member payment of \$33.50.

Copayments

A copayment is the stated amount you must pay for certain covered services before the Plan makes its payment. For instance, when you visit a PPO provider for a covered outpatient visit, after you pay the \$15 copayment, the Plan will pay the remainder of the covered charges or, when you receive services from a surgeon, the Plan will pay its regular benefits after a \$50 copayment.

Cost Sharing *continued*

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charges. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges \$100 for a service but routinely waives the 30% coinsurance, the actual charge is \$70. The Plan will pay \$49 (70% of the actual charge of \$70).

Annual maximums

There is a \$2,000 cumulative annual maximum for outpatient therapy services (physical therapy, speech therapy, occupational therapy; chiropractic and acupuncture services).

Lifetime maximums

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

General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan, or be used in the prosecution or defense of a claim under the Plan.** This brochure is based on text included in the contract between OPM and the Union and is intended to be the complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 33–35 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

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

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

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

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

General Limitations *continued*

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury that medical benefits are determined by the Office of Workers' Compensation Programs (OWCP) to be payable for under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third-party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

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

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third-party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. The Plan has the right to be reimbursed for benefits paid or payable on behalf of a Plan enrollee or a covered family member as the result of an illness or injury caused by a third party. When a Plan enrollee or a covered family member makes a damage claim against a third party or his or her uninsured or underinsured auto policy, as a result of an injury or illness, the Plan may assert a lien on the proceeds of that claim in order to reimburse itself to the full amount of benefits it is called upon to pay. The Plan's lien will apply to any and all recoveries for such claim whether by court order or out-of-court settlement. A Plan enrollee or covered family member must cooperate in the assertion of the Plan's lien by giving an assignment of claim proceeds to the Plan, and by accepting the Plan's lien for the full amount of benefits paid or payable on behalf of the Plan enrollee or covered family member.

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

Overpayments

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

Vested rights

An enrollee does not have a vested right to the benefits in this brochure in 1999 or later years, and does not have a right to benefits available prior to 1998 unless those benefits are contained in this brochure.

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

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

General Limitations *continued*

Inpatient hospital care

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

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 1-800-410-7778 for assistance.

Physician services

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

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

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

If your physician is not a Plan PPO doctor but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's **High Option surgery** benefit, the Plan will pay **70%** of the Medicare-approved amount. You will only be responsible for the coinsurance equal to **30%** of the Medicare-approved amount.

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

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

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 1-800-410-7778.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to ensure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Plan reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 9); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat
- Furnished by household members or immediate relatives, such as spouse; parents; grandparents; children; brothers or sisters by blood, marriage, or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- Not specifically listed as covered
- Investigational or experimental
- Not provided in accordance with accepted professional medical standards in the United States
- Not medically necessary for the treatment or diagnosis of illness or injury
- They are associated with care that is not covered, although they are covered otherwise (e.g., Inpatient Hospital Benefits are not payable for non-covered cosmetic surgery)

Benefits will not be paid for:

- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Plan will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 10–11), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 34), or State premium taxes however applied
- Weight control or treatment of obesity, except surgery for documented morbid obesity
- Outpatient nutritional supplies that do not require a prescription and are not furnished in connection with a covered professional service or in connection with durable medical equipment
- Expenses incurred while not covered by this Plan
- Educational, recreational, or milieu therapy, whether in or out of the hospital
- Services and supplies for cosmetic purposes, except as provided under Surgical Benefits/Limited benefits/Cosmetic surgery
- Biofeedback
- Sex transformation; diagnosis or treatment of sexual dysfunction/inadequacy; penile prosthesis
- Eyeglasses, contact lenses, and hearing aids, except as provided under Additional Benefits
- Orthotics and appliances used to treat temporomandibular joint dysfunction
- Cardiac rehabilitation
- Custodial care (see definition) or domiciliary care
- Travel, even if prescribed by a doctor, except as provided under the Ambulance benefit (see page 23)
- Handling Charges/Administrative or late charges, including interest, billed by providers of care
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services and/or supplies not listed as covered in this brochure

Benefits

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

Precertification

The medical necessity of your hospital admission **must** be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. If your stay is greater than 23 hours, services will be considered inpatient, subject to precertification guidelines. See pages 32–33 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. For information on when Medicare is primary, see pages 33–35.

Room and board

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

PPO benefit

High Option: The Plan pays **100%** with no deductible.

Standard Option: After the \$150 deductible, the Plan pays **100%**.

Non-PPO benefit

After the \$250 deductible, the Plan pays **100%**.

After the \$300 deductible, the Plan pays **100%**.

Other charges

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

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

Limited benefits

Organ/tissue transplants

The maximum benefit for any organ/tissue transplant, as described on page 15, is \$300,000 per occurrence. Included in the \$300,000 maximum are hospital, surgical, and other medical expenses. The cost of related outpatient prescription drugs is not subject to this limit. Chemotherapy when supported by a bone marrow transplant or autologous stem cell support is covered only for specific diagnoses listed on page 15.

Hospitalization for dental work

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

Inpatient Hospital Benefits *continued*

Related benefits

- Pre-surgical testing** See Other Medical Benefits, page 22, for benefits for diagnostic tests and procedures prior to an admission for surgery.
- Professional charges** See page 20 for in-hospital doctors' visits.

What is not covered

- A hospital admission, or portion thereof, that is not medically necessary (see definition), including an admission for medical services that did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered
- Personal comfort items such as radio, television, telephone, guest beds, admission kits or other comfort items
- Charges by institutions that do not meet the definition of a hospital
- Inpatient private-duty nursing
- Custodial care (as defined on page 38), even when provided by a hospital

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

Surgical Benefits

What is covered

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

Hospital inpatient or outpatient

PPO benefit

High Option: The Plan pays 100% of the covered charges after a \$50 copayment.

Standard Option: The Plan pays 95% of the covered charges after a \$50 copayment.

Non-PPO benefit

High Option: The Plan pays 70% of the reasonable and customary charges after a \$50 copayment.

Standard Option: The Plan pays 70% of the reasonable and customary charges after a \$50 copayment.

The copayment applies to each independent surgical procedure.

Multiple surgical procedures

Multiple surgical procedures performed by the same surgeon, through the same incision, and during the same operative session will be paid as follows:

PPO benefit

High Option: The Plan pays 100% of the covered charges after a \$50 copayment for the primary procedure; 100% of half of the covered charges for the secondary procedure.

Standard Option: The Plan pays 95% of the covered charges after a \$50 copayment for the primary procedure; 95% of half of the covered charges for the secondary procedure.

Non-PPO benefit

High Option: The Plan pays 70% of the reasonable and customary charges for the primary procedure after a \$50 copayment; 70% of half of the reasonable and customary charges for the secondary procedure.

Standard Option: The Plan pays 70% of the reasonable and customary charges for the primary procedure after a \$50 copayment; 70% of half of the reasonable and customary charges for the secondary procedure.

Surgical Benefits *continued*

Incidental procedures	An incidental procedure (e.g., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) can be part of the primary surgery or unrelated to the objective of the operative session. If a surgical procedure is deemed by the Plan to be incidental to the total surgery, benefits will not be provided for the incidental portion.
Assistant surgeon (inpatient/outpatient)	When the services of an assistant surgeon are required by the primary surgeon, the Plan pays as follows:
PPO benefit	Both Options: The Plan pays 20% of the covered charges after a \$50 copayment.
Non-PPO benefit	Both Options: The Plan pays an additional allowance of up to 20% of the reasonable and customary charges for the surgery after a \$50 copayment.
Anesthesia	
PPO benefit	High Option: The Plan pays 100% of the covered charges after a \$50 copayment. Standard Option: The Plan pays 95% of the covered charges after a \$50 copayment.
Non-PPO benefit	High Option: The Plan pays 70% of the reasonable and customary charges after a \$50 copayment. Standard Option: The Plan pays 70% of the reasonable and customary charges after a \$50 copayment.
Pre-surgical testing	See Other Medical Benefits, pages 20–22.
Organ/tissue transplants and donor expenses	<p>Benefits will be provided the same as for any other illness or injury for covered expenses incurred for surgical transplant of a body organ/tissue (as defined below). Related donor medical and hospital expenses are covered when the recipient is covered by the Plan.</p> <p>Surgical transplant of body organ/tissue means transfer of a body organ(s)/tissue(s) from the donor to the recipient (allogeneic) or a bone marrow graft in which the donor and recipient are the same person (autologous). For purposes of this Plan, body organ/tissue includes only the organs and tissues listed below as “What is covered.”</p> <p>Donor means a person who undergoes a surgical operation for the purpose of donating a body organ(s)/tissue(s) for transplant surgery. Coverage for donor screening tests for organ/tissue transplants are limited to those performed on the actual donor.</p>
What is covered	<p>Benefits will be provided for the following transplants subject to the limitations shown:</p> <ul style="list-style-type: none">• Cornea, heart, kidney, liver, pancreas, heart/lung, single lung and double lung transplants• Bone marrow and stem cell support as follows:<ul style="list-style-type: none">Allogeneic (donor) bone marrow transplants: leukemia, aplastic anemia, severe combined immuno-deficiency disease, Wiscott-Aldrich syndrome, or advanced Hodgkin’s disease.Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s disease; advanced non-Hodgkin’s lymphomas, resistant or recurrent neuroblastoma; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; breast cancer; multiple myeloma; and epithelial ovarian cancer.• Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan. <p>The maximum benefit for any organ/tissue transplant(s) is \$300,000 per occurrence. Included in the \$300,000 maximum are hospital, surgical, and medical expenses of the recipient but not the covered expenses of the donor. The cost of outpatient prescription drugs related to the transplant is not subject to the \$300,000 limit. Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support, is covered only for the specific diagnoses listed above.</p>

Surgical Benefits *continued*

What is not covered

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

Oral and maxillofacial surgery

The following procedures are covered:

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

Note: Procedures that involve the teeth or their supporting structures, such as periodontal membrane, gingiva, and alveolar bone, are not considered covered oral surgery. These procedures may be considered as covered dental procedures under the **High Option** dental benefits. There is no coverage for dental implants or related procedures. (See pages 26–27).

Mastectomy Surgery

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

Related benefit

Pre-surgical testing

Outpatient diagnostic tests and procedures performed prior to surgery are covered under Outpatient diagnostic laboratory, X-ray and machine diagnostic tests benefits as described under Other Medical Benefits, page 22.

Related benefit

Eyeglasses/lenses

Eyeglasses or contact lenses to correct an impairment directly caused by an accidental injury or covered intraocular surgery are covered as Additional Benefits on page 23–24.

Limited benefits

Cosmetic surgery

Cosmetic surgery (see definition) and all services related thereto are limited to surgery necessary to correct a congenital anomaly (see definition), to promptly repair following accidental injury, and to the initial breast reconstruction following a mastectomy. Patient may have replacement prosthesis.

What is not covered

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

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

Maternity Benefits

What is covered

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

Inpatient hospital

Precertification

Precertification is not required for maternity admissions for routine deliveries. However, if your medical condition requires that you stay more than 48 hours after a regular delivery or 96 hours after a cesarean section, you, your physician or the hospital must contact the Mail Handlers Benefit Plan for certification of the additional days. If the certification for additional days is not obtained and a retrospective medical review determines the additional days were not medically necessary, the Plan will not pay for charges incurred on those noncertified days. If certification is not obtained but the benefits are otherwise payable, benefits for the admission will be reduced by \$500. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by \$500. See pages 32–33 for details.

Newborn precertification

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

Room and board

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

PPO benefit

High Option: The Plan pays **100%** with no deductible.

Standard Option: The Plan pays **100%** after the \$150 deductible.

Non-PPO benefit

High Option: The Plan pays **100%** after the \$250 deductible.

Standard Option: The Plan pays **100%** after the \$300 deductible.

Other charges

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

Birthing Centers

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

Obstetrical care

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

PPO benefit

High Option: The Plan pays **100%** of the covered charges after a \$50 copayment.

Standard Option: The Plan pays **95%** of the covered charges after a \$50 copayment.

Non-PPO benefit

High Option: The Plan pays **70%** of the reasonable and customary charges after a \$50 copayment.

Standard Option: The Plan pays **70%** of the reasonable and customary charges after a \$50 copayment.

Maternity benefits will be paid at the termination of pregnancy.

Maternity Benefits *continued*

Anesthesia

PPO benefit

High Option: The Plan pays **100%** of the covered charges after a \$50 copayment.

Standard Option: The Plan pays **95%** of the covered charges after a \$50 copayment.

Non-PPO benefit

High Option: The Plan pays **70%** of the reasonable and customary charges after a \$50 copayment.

Standard Option: The Plan pays **70%** of the reasonable and customary charges after a \$50 copayment.

Newborn exam

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

PPO benefit

Both Options: The Plan pays **100%** of the covered charges after a \$15 copayment per visit.

Non-PPO benefit

High Option: The Plan pays **70%** of the reasonable and customary charges.

Standard Option: The Plan pays **70%** of the reasonable and customary charges, after you pay the \$100 per person calendar year deductible.

Related benefits

Outpatient X-ray and laboratory tests

Outpatient X-ray procedures and laboratory tests related to maternity care are covered under Other Medical Benefits.

Diagnosis and treatment of infertility

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

Voluntary sterilization

Benefits for voluntary sterilization are paid under Surgical Benefits.

For whom

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

What is not covered

- Assisted Reproductive Technology (ART) procedures such as artificial insemination, in vitro fertilization, embryo transfer and gamete intrafallopian transfer (GIFT), as well as services and supplies related to ART procedures are not covered
- A reversal of surgically induced sterilization
- Contraceptive drugs, except as covered under Prescription Drug Benefits (see pages 24–25)
- Charges for care received after enrollment in this Plan ends
- Stand-by doctors
- Home uterine monitoring devices

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

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Mental conditions

Mental Conditions/Substance Abuse Benefits are paid instead of any other benefits under this Plan, for all expenses for treatment of mental conditions and substance abuse as shown below and on the next page.

Inpatient care

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

Precertification

The medical necessity of your admission to a hospital must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See pages 32–33 for details.

PPO benefit

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

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

Non-PPO benefit

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

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

Inpatient visits

Related benefits

Doctors' inpatient visits are paid at **70%** for **High Option**; under **Standard Option 70%** of the reasonable and customary charges, after you pay the \$100 per person calendar year deductible.

Outpatient care

Outpatient visits for diagnosis and treatment of mental conditions and substance abuse are covered as follows:

High Option and **Standard Option** pay **50%** of the reasonable and customary charges, limited to 20 outpatient visits per year.

One day in a partial hospitalization/day treatment program is considered as one outpatient visit.

Related benefits

Electroshock therapy and diagnostic tests and laboratory procedures are paid at **70% (High Option)** or **70% (Standard Option)** of the reasonable and customary charges, after you pay the \$100 per person calendar year deductible under **Standard Option**.

What is not covered

- Services by pastoral counselors, family/marital counselors, alcohol/substance abuse counselors, and other non-covered providers.
- Counseling or therapy for marital, family, educational, behavioral, or sexual problems.
- Services rendered or billed by institutions that do not meet the definition of a hospital, including licensed residential treatment centers or facilities that are accredited by JCAHO as subacute care facilities.
- A hospital admission, or portion thereof, when, in the Plan's judgement, the confinement is not medically necessary, i.e., the care provided did not require an acute hospital (inpatient) setting, but could have been provided in some other setting without adversely affecting the patient's condition or the quality of the care rendered.

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

Other Medical Benefits

What is covered

Physician services

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

Hospital visits

PPO benefit

Both Options: The Plan pays **100%** of the covered charges after a \$15 copayment per visit.

Non-PPO benefit

High Option: The Plan pays **70%** of the reasonable and customary charges.

Standard Option: The Plan pays **70%** of the reasonable and customary charges, after you pay the \$100 per person calendar year deductible.

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

PPO benefit

Both Options: The Plan pays in full after you pay a \$15 copayment per visit.

Non-PPO benefit

High Option: The Plan pays **70%** of the reasonable and customary charges.

Standard Option: The Plan pays **70%** of the reasonable and customary charges, after you pay the \$100 per person calendar year deductible.

For additional services provided during an office visit, see outpatient diagnostic X-ray and machine tests and outpatient laboratory tests on page 22.

Other outpatient visits

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

PPO benefit

Both Options: The Plan pays in full after you pay a \$15 copayment per visit.

Non-PPO benefit

High Option: The Plan pays **70%** of the reasonable and customary charges.

Standard Option: The Plan pays **70%** of the reasonable and customary charges, after you pay the \$100 per person calendar year deductible.

For additional services provided during an office visit, see outpatient diagnostic X-ray and machine tests and outpatient laboratory tests on page 22.

There is one \$2,000 annual maximum per person (for both PPO and non-PPO benefits) related to any combination of outpatient therapy, chiropractic and acupuncture services.

The Plan will not pay in excess of the \$2,000 annual maximum for these services, even from the Catastrophic Benefit Protection.

Other Medical Benefits *continued*

Hospital outpatient care

Surgical facility services

Under both options when a member undergoes a covered outpatient surgical procedure, the Plan pays the surgical facility charge for related services and supplies rendered on that day and billed by the outpatient department of a hospital or surgi-center as shown below. If the stay is greater than 23 hours, services will be considered inpatient care subject to precertification requirements (see pages 13–14). Note: For services rendered and billed by the surgeon and/or anesthesiologist, see Surgical Benefits on pages 14–16.

PPO benefit

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

Non-PPO benefit

High Option: The Plan pays 70% of the covered charges after the \$250 per occurrence deductible.

Standard Option: The Plan pays 70% of the covered charges after the \$300 per occurrence deductible.

Other outpatient care

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

PPO benefit

Both Options: The Plan pays 95% of the covered charges.

Non-PPO benefit

High Option: The Plan pays 70% of the reasonable and customary charges.

Standard Option: The Plan pays 70% of the reasonable and customary charges, after you pay the \$100 per person calendar year deductible.

Note: Retail pharmacy charges for chemotherapy and prescriptions to treat the side effects of chemotherapy are covered under Prescription Drug Benefits, as described on pages 24–25.

Emergency treatment

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

PPO benefit

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

Non-PPO benefit

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

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

PPO benefit

Both Options: The Plan pays 95% of the covered charges.

Non-PPO benefit

Both Options: After the \$50 deductible per visit for the facility charge (hospital or urgent care center), the Plan pays 75% of the reasonable and customary charges.

Other Medical Benefits *continued*

Outpatient diagnostic X-ray and machine tests

For covered diagnostic X-ray and other machine diagnostic tests related to a covered illness or injury, the Plan pays as follows:

PPO benefit

Both Options: After a \$15 copayment per provider per day, the Plan pays PPO charges in full for machine tests and X-rays.

Non-PPO benefit

High Option: The Plan pays **70%** of the reasonable and customary charges.

Standard Option: The Plan pays **70%** of the reasonable and customary charges, after you pay the \$100 per person calendar year deductible.

Outpatient laboratory

For covered diagnostic laboratory testing including pre-surgical testing, venipuncture (blood drawing) and allergy testing, the Plan pays as follows:

PPO benefit

Both Options: The Plan pays PPO charges in full after a \$5 copayment for each billed test. If laboratory tests are billed by a doctor, there will be one \$15 copayment for the office visit and a \$5 copayment for each billed laboratory test.

Non-PPO benefit

High Option: The Plan pays **70%** of the reasonable and customary charges.

Standard Option: The Plan pays **70%** of the reasonable and customary charges, after you pay the \$100 per person calendar year deductible.

Routine services

The following routine (screening) services, including associated office visits, are covered as preventive care:

Breast cancer screening

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

- From ages 35 through 39, one mammogram screening during this five-year period;
- From ages 40 through 64, one mammogram screening every calendar year;
- At age 65 or over, one mammogram screening every two consecutive calendar years.

See outpatient diagnostic X-ray and machine tests described above.

Cervical cancer screening

Annual coverage of one Pap smear for women age 18 and older.

Colorectal cancer screening

Annual coverage of one fecal occult blood (stool) test for members age 40 and older.

Prostate cancer screening

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

See outpatient laboratory benefit described above.

Limited benefits

Childhood immunizations

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

PPO benefit

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

Non-PPO benefit

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

Other Medical Benefits *continued*

Smoking cessation benefit

The Plan will pay up to \$100 for enrollment in one smoking cessation program per member per lifetime. All claims for smoking cessation benefits will be paid directly to you. Prescription drugs for smoking cessation are paid under Prescription Drug Benefits, and their cost does not count toward the \$100 limit; see pages 24–25.

Well-child care

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

PPO benefit

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

Non-PPO benefit

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

What is not covered

- Routine physical examinations, except for well-child care visits.
- Routine X-ray and laboratory tests except for routine mammograms, an annual routine Pap smear, an annual PSA test, and an annual stool test for occult blood.
- Chelation therapy, except for acute arsenic, gold, mercury, or lead poisoning.
- Charges for thermography and related visits.
- Chemotherapy supported by a bone marrow transplant, or with stem cell support, for any diagnosis not listed as covered on page 15.
- Laboratory handling charges.

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

Additional Benefits

High Option and Standard Option pay benefits as described below.

Ambulance benefit

The Plan pays **in full** for professional local ambulance service (within 100 miles) to the first hospital where treated, from that hospital to the next nearest one if necessary treatment is not available or suitable at the first hospital, and from the hospital to another medical facility if required for the patient to receive necessary treatment. Air ambulance is covered if no emergency ground transportation is available or suitable and the patient's condition warrants immediate evacuation.

What is not covered

Ambulance or other transportation services used for the purposes of receiving non-emergency outpatient care.

Durable medical equipment

Notify the Plan immediately at 1-800-410-7778 when durable medical equipment has been prescribed and if the anticipated purchase price exceeds \$1,000 or rental charges are expected to cost at least \$500 per month. Failure to obtain preauthorization will reduce your covered benefits by \$500. After a \$100 deductible per item purchased as an outpatient, the Plan pays reasonable and customary charges for the rental (or purchase, at the Plan's option, if less expensive), of durable medical equipment (see definition) when recommended by an M.D. or D.O. The Plan will also pay for necessary repair or adjustments to purchased equipment and supplies used solely in connection with the durable medical equipment.

Additional Benefits *continued*

What is not covered

- Durable medical equipment replacements provided less than three years after the last one for which benefits were paid.
- Charges for service contracts for purchased durable medical equipment.
- Items that are not durable medical equipment (see definitions), such as outpatient exercise equipment (including treadmills and exercise bicycles), air conditioners, air purifiers, humidifiers, ultraviolet lighting (except for the treatment of psoriasis), and motorized scooters, computer “story boards” or “light talkers” or other communication aids for communication impaired individuals; lifts, such as seat, chair or van lifts; safety and hygienic equipment.

Eyeglasses/lenses

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

What is not covered

- Routine eye exams

Hearing aid

The Plan pays up to \$200 for one hearing aid per ear (including examination) if required to correct an impairment directly caused by an accident. This benefit is available up to 120 days following the accident, provided you are still enrolled in this Plan.

Hospice care program

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

Nursing care services

The Plan pays up to \$50 per home visit, to an annual maximum of \$700, for the services of a registered graduate nurse (R.N.) or the services of a licensed practical nurse (L.P.N.), if recommended by an M.D. or D.O.

Orthopedic and prosthetic appliances

Notify the Plan immediately at 1-800-410-7778 when orthopedic and/or prosthetic appliances have been prescribed and the anticipated purchase price of an item exceeds \$1,000 or rental charges are expected to cost at least \$500 per month. Failure to obtain preauthorization will reduce your covered benefits by \$500. After a \$100 deductible per item, the Plan pays reasonable and customary charges for an orthopedic or prosthetic appliance (see definition) when recommended by an M.D. or D.O.

What is not covered

- Podiatric (foot) orthotics/orthopedic appliances (devices that can be placed in or on the shoe) such as arch supports, metatarsal bars, metatarsal pads, heel pads, heel cups, or corrective (orthopedic) shoes unless attached to a brace.
- Supportive devices such as elastic stockings, corsets, elastic bandages or trusses.
- Wigs.

Rabies shots

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

Prescription Drug Benefits

What is covered

The following medications and supplies are covered when prescribed by a doctor and furnished by a pharmacy or mail order program:

- Drugs and medicines that by Federal law of the United States require a doctor’s written prescription, including chemotherapy and drugs used to treat the side effects of chemotherapy
- Disposable needles and syringes, alcohol swabs, and ostomy supplies
- Insulin and related testing material

Prescription Drug Benefits *continued*

What is covered

(continued)

- Hormone-based contraceptives, including Norplant (Norplant insertions are covered under Surgical Benefits)
- Smoking deterrents

Related benefits

Chemotherapy

See page 21 for benefits for chemotherapy rendered in an outpatient facility.

What is not covered

- Outpatient medical supplies that do not require a prescription except those listed above
- Vitamins and nutritional supplements, except those requiring a prescription by law
- Anorexiant/appetite suppressants or prescription drugs for weight loss
- Supplies for prenatal nutrition
- Prescription Drug Benefits as a secondary payor in cases when members have other prescription drug coverage

PCS participating pharmacy and drug claims from outside the United States

High Option: After satisfying the \$250 deductible per person, the Plan pays 75% of actual charges.

Standard Option: After satisfying the \$600 deductible per person, the Plan pays 70% of the actual charges.

After meeting the \$250 High Option deductible or the \$600 Standard Option deductible per person, the Plan pays 75% under High Option and 70% under Standard Option of actual charges. Present your Mail Handlers Benefit Plan ID card to the pharmacy with your prescription and pay the applicable deductible or coinsurance. The PCS participating pharmacy files your claim and is reimbursed by the Plan. Call the Plan at 1-800-410-7778 to find out the names of PCS participating pharmacies in your area. Note: In most cases, refills cannot be obtained until 75% of the drug has been used.

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

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

High Option: After satisfying the \$250 deductible per person, the Plan pays 50% of actual charges.

Standard Option: After satisfying the \$600 deductible per person, the Plan pays 50% of the actual charges.

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

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

Mail Handlers Benefit Plan
Post Office Box 6423
Rockville, MD 20849-6423

Effective 2/1/98, claims should be submitted to:

Mail Handlers Benefit Plan
Post Office Box 45118
Jacksonville, FL 32232-5118

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

Prescription Drug Benefits *continued*

Mail Order Program for Maintenance Medications

The Plan and PCS Health Systems have introduced a mail service program for enrollees who take maintenance medications. Maintenance drugs are typically prescribed to treat long term medical conditions such as diabetes, high blood pressure, and asthma. To obtain additional information about the Mail Order Maintenance Drug Program, call the Plan at 1-800-410-7778 Monday – Friday, 8 A.M. – 8 P.M. ET.

High Option: After satisfying the \$250 deductible per person, the Plan pays 75% of actual charges.

Standard Option: After satisfying the \$600 deductible per person, the Plan pays 70% of the actual charges.

High Option Dental Benefits

What is covered

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

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

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

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

The following is a partial schedule of dental allowances.

ADA CODE	DIAGNOSTIC	
00120	Periodic oral examination (limit one per year).....	\$ 7.50
00210	Intraoral — complete series (including bitewings) of X-rays (limit one per year)	22.00
00220	Intraoral-periapical — first film	3.25
00230	Intraoral — each additional film	2.25
00240	Intraoral — occlusal film	7.50
00270	Bitewing single film	2.75
00290	Posterior-anterior or lateral skull and facial bone survey	13.00
00330	Panoramic film	22.00
	PREVENTIVE (dollar amount shown is limit per calendar year)	
01110	Prophylaxis — adult (age 13 and over)	14.25
01120	Child to age 13.....	12.00
01203	Topical application of fluoride (prophylaxis not included), child	7.50
01204	Adult	7.50
01351	Sealant, per tooth.....	7.50
01510	Space maintainer — fixed — unilateral.....	34.00
	RESTORATIVE SERVICES (includes liners, bases, and analgesia)	
02140	1 surface, permanent.....	13.00
02150	2 surfaces, permanent	20.75
02160	3 surfaces, permanent	27.50
02951	Reinforcement pins, each pin	8.25
	ENDODONTICS (includes local anesthesia)	
03110	Pulp cap — direct.....	16.50
03310	Root canal therapy, one canal.....	96.75
03320	Root canal therapy, two canals.....	136.25
03330	Root canal therapy, three canals.....	178.00
03410	Apicoectomy.....	55.00

High Option Dental Benefits *continued*

ADA CODE	PERIODONTICS (includes local anesthesia)	
04320	Provisional splinting	81.25
04341	Periodontal scaling and root planing, per quadrant	13.00
04910	Periodontal maintenance procedures.....	13.00
	CROWN AND BRIDGE (includes local anesthesia)	
02510	Inlay, metallic — one surface.....	68.00
02710	Crown, resin (laboratory)	108.75
02720	Crown, resin with high noble metal	178.00
02740	Crown, porcelain/ceramic substrate	136.25
02750	Crown, porcelain fused to high noble metal.....	178.00
02752	Crown, porcelain fused to noble metal	178.00
02790	Crown, full cast high noble metal	149.50
02810	Crown, ¾ cast metallic.....	102.25
02952	Cast post and core in addition to crown.....	68.00
02954	Prefabricated post and core in addition to crown	34.00
02980	Crown repair	13.00
02920	Recement crown	27.50
	PONITICS (includes local anesthesia)	
06210	Cast high noble metal.....	\$ 82.50
06240	Porcelain fused to high noble metal.....	136.25
	DENTURES (prosthetics)	
05110	Complete denture — maxillary (including necessary adjustments within 6 months)	239.75
05120	Complete denture — mandibular (including necessary adjustments within 6 months)	239.75
05130	Immediate denture — maxillary	272.50
	Immediate denture — mandibular	272.50
05211	Maxillary partial denture — resin base.....	217.75
05510	Repair, broken complete denture base	20.75
05520	Replace missing or broken teeth, complete denture (each tooth).....	9.75
05630	Replace or repair broken clasp.....	40.50
05640	Replace broken teeth (per tooth).....	13.00
05650	Add tooth to existing partial denture	34.00
05660	Additional clasp to existing denture.....	40.50
05710	Rebase complete maxillary denture	68.00
	ORAL SURGERY (includes local anesthesia)	
04210	Gingivectomy or gingivoplasty, per quadrant.....	102.50
04260	Osseous surgery, including flap entry and closure, per quadrant.....	137.50
07110	Extraction of single tooth	15.00
07120	Each additional tooth at same session	12.00
07210	Surgical extraction of erupted tooth.....	23.00
07285	Biopsy of oral hard tissue.....	34.00
07310	Alveoplasty in conjunction with extraction, per quadrant.....	44.00
07450	Removal of odontogenic cyst or tumor/lesion, diameter up to 1.25 cm.....	66.00
07510	Incision and drainage of abscess, intraoral soft tissue.....	13.00
07960	Frenulectomy (frenectomy or frenotomy) separate procedure	61.50
	MISCELLANEOUS SERVICES	
09110	Palliative treatment of dental pain, minor procedure.....	7.50
09220	General anesthesia, first 30 minutes.....	8.75
09221	Each additional 15 minutes	4.38
09310	Consultation by other than the attending dentist	20.75

Related benefits

Hospitalization for dental treatment

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

High Option Dental Benefits *continued*

Accidental injury

Repair of sound, natural teeth following accidental injury (including, but not limited to expenses for X-rays, crowns, bridgework or dentures) performed within 12 months of the accident, is covered under Surgical Benefits and Other Medical Benefits. This benefit for accidental injury to sound natural teeth is available to members enrolled under the Standard Option. Masticating (chewing) incidents are not considered to be accidental injuries. Accidental dental injury is covered at 100% for charges incurred within 72 hours of an accident (see Emergency treatment on page 21). There will be no exceptions to the 72-hour time limit.

Oral and maxillofacial surgery

For coverage of oral and maxillofacial surgery, including coverage of removal of impacted teeth, see page 16.

What is not covered

- Charges related to orthodontia
- Oral hygiene instructions
- Denture replacements (if benefits were provided by this Plan within the last five years)
- Temporary dental services
- Dental implants or related surgical benefits
- Inpatient or outpatient hospital charges for covered dental procedures other than covered oral surgery unless precertified
- Orthotics and other occlusal appliances used to treat temporomandibular joint dysfunction

How to Claim Benefits

Claim forms and identification cards

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier at 1-800-410-7778 to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

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

How to file claims

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA 1500, Health Insurance Claim Form. Claims submitted by enrollees may be submitted on the HCFA 1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payor (such as Medicare or no-fault) must be sent with your claim.
- Bills for private-duty nurses must show that the nurse is a registered or licensed practical nurse and must include nursing notes.
- Claims for rental or purchase of durable medical equipment, private-duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

How to Claim Benefits *continued*

How to file claims (*continued*)

Cancelled checks, cash register receipts or balance due statements are not acceptable. After completing a claim form and attaching proper documentation, send claims to:

Mail Handlers Benefit Plan
Post Office Box 6222
Rockville, MD 20849-6222

Effective 2/1/98, submit claims to:

Mail Handlers Benefit Plan
Post Office Box 45118
Jacksonville, FL 32232-5118

For prescription drug claims, see page 25.

Records

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

Submit claims promptly

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

Direct payment to hospital or provider of care

Claims for in-hospital confinements that are submitted by the hospital will be paid directly to the hospital. 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.

When more information is needed

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

Confidentiality

Medical and other information provided to the Carrier, including claim files, is kept confidential and will be used only: 1) by the Carrier and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of bona fide medical research or education. As part of its administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

Disputed claims Reconsideration

If a claim for payment is denied (or a portion of the claim) by the Carrier, you must ask the Carrier, in writing, and within six months of the date of the denial, to reconsider its decision before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit). OPM will not review your request unless you demonstrate that you gave the Carrier an opportunity to reconsider your claim. Before you ask the Carrier to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did they use the correct procedure code for the service(s) performed (surgery, laboratory test, X-ray, office visit, etc.). Indicate any complications of any surgical procedure(s) performed. Include

How to Claim Benefits *continued*

Reconsideration (*continued*)

copies of an operative or procedure report, or other documentation that supports your claim. Your written request to the Carrier must state why, based on specific benefit provisions in this brochure, you believe a denied claim for payment should have been paid.

Within 30 days after receipt of your request for reconsideration, the Carrier must affirm the denial in writing to you, pay the claim, or request additional information that is reasonably necessary to make a determination. If the Carrier asks a provider for information, it will send you a copy of this request at the same time. The Carrier has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Carrier will base its decision on the information it has on hand.

OPM review

If the Carrier affirms its denial, you have the right to request a review by OPM to determine whether the Carrier's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Carrier's letter affirming its initial denial.

You may also ask OPM for a review if the Carrier fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Carrier. In this case, OPM must receive a request for review within 120 days of your request to the Carrier for reconsideration or of the date you were notified that the Carrier needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with the request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the Carrier should have paid the denied claim. If the Carrier has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Carrier requesting reconsideration;
- A copy of the Carrier's reconsideration decision (if the Carrier failed to respond, provide instead (a) the date of your request to the Carrier, or (b) the dates the Carrier requested and you provided additional information to the Carrier);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms); and
- Your daytime phone number.

Medical documentation received from you or the Carrier during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

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

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Carrier until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal courts.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Carrier's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

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

Protection Against Catastrophic Costs

Catastrophic protection

The Plan pays 100% of reasonable and customary eligible charges for the remainder of the calendar year when out-of-pocket expenses in that calendar year exceed \$3,000 under High and Standard Option for you and any covered family members. Under family coverage, out-of-pocket expenses for family members accumulate towards one \$3,000 maximum.

PPO Providers: When your eligible out-of-pocket expenses from using PPO providers (when the services are eligible to be received from PPO providers) exceed \$2,000 under the **High Option**, the Plan pays 100% of its covered charges for covered expenses when you continue to select PPO providers for the remainder of the calendar year. Whether or not you use PPO providers, your share of out-of-pocket expenses will not exceed \$3,000 in a calendar year.

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

- The 30% **High**/30% **Standard** coinsurance you pay for surgery (including obstetrical care); anesthesia; doctors' inpatient and outpatient medical visits; diagnostic laboratory tests and X-rays; and dental work if required for repair of an accidental injury;
- The 25% coinsurance you pay for outpatient emergency illness treatment;
- The 30% coinsurance for outpatient surgical facility charges, chemotherapy, X-ray or radium treatment, hemodialysis and peritoneal dialysis, and hyperbolic oxygen therapy;
- The 5% coinsurance you pay for emergency illness under both High and Standard Option PPO benefits;
- The 5% coinsurance you pay under Standard Option for PPO surgeons and anesthesiologists; and
- The 5% coinsurance you pay under High and Standard Options for PPO facilities for chemotherapy, hemodialysis and radiation therapy.

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

- Copayments;
- Coinsurance for chiropractor visits; physical, speech, occupational and acupuncture therapy;
- Deductibles;
- Non-covered services and supplies;
- Expenses in excess of reasonable and customary charges or benefit maximums;
- Expenses for diagnosis/treatment of mental conditions or substance abuse, hospice care, nursing care, prescription drugs, or dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with the Plan's precertification requirements (see pages 32–33) or preauthorization of durable medical equipment; orthopedic and/or prosthetic appliances.

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** the effective date of your coverage in this Plan.

If you have already met the covered out-of-pocket maximum expense level in full, your old plan's catastrophic protection benefit will continue to apply until the effective date. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your new plan. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Other Information

Precertification

Precertify before admission

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

To precertify a scheduled admission:

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

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

Need additional days?

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

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payor for the hospital confinement (see pages 33–35). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using Lifetime Reserve Days or when the patient is enrolled in Medicare Part A and inpatient services are rendered in a Department of Defense (DoD) or Department of Veterans Affairs facility.
- You are confined in a hospital outside the United States and Puerto Rico.
- Your stay is less than 23 hours.
- When the discharge for your maternity admission is within 48 hours after a regular delivery or within 96 hours after a cesarean section delivery.

Emergency admissions

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

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

Other considerations

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

Precertification *continued*

If you do not precertify

If precertification is not obtained before admission to the hospital or after 48 hours after a regular delivery or 96 hours after a cesarean section delivery (or within two business days following the day of an emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary the inpatient hospital room and board benefits will not be paid. However, medically necessary hospital services and supplies otherwise payable will be considered by the Carrier at 70% of actual charges.

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

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient room and board hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medically necessary services and supplies otherwise payable will be considered by the Carrier at 70% of actual charges.

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare (see pages 9–11).

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

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

This Plan is primary if:

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

For purposes of this section, "employed by the Federal Government" means you are a Federal employee and you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Medicare is primary if:

- 1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
- 2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
- 3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
- 4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;

This Plan and Medicare *continued*

Medicare is primary if: (*continued*)

- 5) You are enrolled in Part B only, regardless of your employment status;
- 6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
- 7) You are a former Federal employee receiving workers' compensation and the Office of Workers' Compensation has determined that you are unable to return to duty;
- 8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
- 9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payor status for the patient under rules 1) through 7) above.

When Medicare is primary

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

Inpatient Hospital Benefits and Mental Conditions/Substance Abuse Benefits: If you are enrolled in Medicare Part A (hospital), this Plan will waive the deductible applicable to inpatient hospital care.

Surgical Benefits: If you are enrolled in Medicare Part B (medical), this Plan will waive the coinsurance and the \$50 copayment applicable to inpatient and outpatient surgical services and anesthesia. The Plan will also waive the deductible for surgical facility for both High and Standard Options.

Other Medical Benefits: If you are enrolled in Medicare Part B (medical), this Plan will waive the coinsurance applicable to diagnostic procedures, chemotherapy, dialysis, and emergency treatment. The Plan will waive the \$100 per person calendar year deductible for **Standard Option** non-PPO benefits for certain services.

No waivers will apply to:

Other Medical Benefits: No waivers will apply to PPO copayments.

Prescription Drug Benefits: The deductible and coinsurance for prescription drugs will not be waived by the Plan.

Additional Benefits: No waivers apply.

When Medicare is the primary payor, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

When you also enroll in a Medicare pre-paid plan

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

Medicare's payment and this Plan

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

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

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the limiting charge is 115 percent of the Medicare approved amount. Under this law, if you use a doctor who does not accept assignment for the claim, the

This Plan and Medicare *continued*

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

doctor is permitted to bill you after the Plan has paid only if the Medicare and Plan payments combined do not total the limiting charge. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. The Medicare Explanation of Benefits (EOB) form will have more information about this limit.

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

How to claim benefits

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

Enrollment Information

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How to claim benefits" on page 28.

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

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system (see Effective date on page 39). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see "If you are hospitalized" below.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such a case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Enrollment Information *continued*

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about when you may change your enrollment; who “family members” are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in the Plan. If you changed plans or plan options, see “If you are a new member” (page 35). In both cases, however, the Plan’s new **rates** are effective the first day of the enrollee’s first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.
- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Carrier promptly.
- If you are an annuitant or former spouse with FEHB coverage and you also are covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You also may remain enrolled in this Plan when you join a Medicare prepaid plan. See pages 33–35 for how this Plan’s benefits are affected when you are enrolled in a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800-638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Enrollment Information *continued*

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she will generally be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to continue your health benefits coverage temporarily under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employee or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the date the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date, and coverage may not exceed the 18- or 36-month period noted above.

Notification and election requirements

- **Separating employees** — Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.
- **Children and former spouses** — **Children** — You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, reaches age 22 or marries.
- **For a former spouse** — You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she

Enrollment Information *continued*

Notification and election requirements *(continued)*

receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of qualifying court order.

Important: The employing office or retirement system must be notified of a child or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the aforementioned choices are available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for pre-existing conditions. If you wish to convert to an individual contract, you must apply in writing to the Carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, for example, divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Definitions

Accidental injury

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

Admission

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

Assignment

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

Calendar year

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

Congenital anomaly

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

Cosmetic surgery

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

Custodial care

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

- 1) personal care, such as help in walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
- 2) homemaking, such as preparing meals or special diets;
- 3) moving the patient;
- 4) acting as companion or sitter;
- 5) supervising medication that can usually be self-administered; or

Definitions *continued*

Custodial care

(continued)

- 6) treatment or services that any person may be able to perform with minimal instruction, including, but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

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

Effective date

The date the benefits described in this brochure are effective:

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

Experimental or investigational drug, device, and medical treatment or procedure

A drug, device or medical treatment or procedure is experimental or investigational:

- 1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- 2) if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- 3) if reliable evidence shows that the consensus of opinion among experts regarding the drug, device 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 or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Group health coverage

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

Hospice care program

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

Definitions *continued*

Medically necessary

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

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

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

Mental conditions/ substance abuse

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

Morbid obesity

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

Orthopedic appliance

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

Prosthetic appliance

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

Reasonable and customary

Unless otherwise indicated, the Plan covers charges to the extent that they are reasonable and customary. The reasonable and customary charges for any non-PPO services or supplies generally is the lesser of either (a) the usual charge made by the provider for the service or supply in the absence of insurance or (b) the charge that the Carrier determines to be in the 90th percentile of the prevailing charges made for the service or supply by providers in the geographic area where it is furnished. The prevailing charges data is collected by the Carrier's underwriter and is updated semiannually. For certain services, exceptions to the general method of determining reasonable and customary may exist.

Non-FEHB Benefits Available to Plan Members

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

- **Vision One Eyecare Program** provides Plan enrollees and eligible dependents the ability to obtain eye exams, frames, eyeglasses and contact lenses at reduced prices from Vision One providers. For more information concerning the Vision One Eyecare Program, you may call 1-800-424-1155 for the name of the eye care center closest to you.
- **Miracle-Ear Hearing Program** provides Plan enrollees and eligible dependents the ability to obtain free hearing tests and evaluations, free counseling, free check-up and cleaning of instruments, and a discount off of suggested retail prices of Miracle-Ear hearing aid products. Consult your Yellow Pages for the Miracle-Ear Center, Miracle-Ear at Montgomery Ward, Sears Hearing Aid Center or simply call the Miracle-Ear Consumer Affairs Department at 1-800-456-6801 for the location nearest you.
- **SDV Vitamins Discount Program** provides enrollees and eligible family members the ability to obtain vitamins, minerals, herbal formulas, weight management products, and over-the-counter pharmaceuticals at a 30% discount off the prices shown in the SDV Vitamins Nutritional Source Book Catalogue. You may call toll-free 1-800-738-8482 to order a catalogue or to place an order. Be sure to mention code MH097 to obtain the discount.

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

- **Hospital Money Plan** provides daily cash benefits for hospitalization. Cash payments of up to \$60 per day are paid directly to enrollees when they or a covered family member are hospitalized for any covered sickness or accident. If confinement is for intensive care, benefits of up to \$120 per day are paid. The money is paid directly to the enrollee and may be spent in any way. For additional information concerning the Hospital Money Plan, you may call 1-800-621-0839.
- **Off-Work Accident Disability Plan** provides \$150 a week when an enrollee is totally disabled by an off-work injury. The program also provides up to \$25,000 for accidental death benefits. If the enrollee has children, up to \$10,000 in educational benefits for each eligible child is provided if death occurs as a result of a covered injury. For more information about the Off-Work Accident Disability Plan, you may call 1-800-621-0839.
- **Dental Supplement Plan** offers increased dental coverage to High Option enrollees and covered dependents. The Dental Supplement Plan will automatically increase benefits for covered diagnostic, preventive and periodontal services by 60%; benefits for all other covered services will increase by 30%. There is no deductible for this plan and no extra claim forms. For more information about the Dental Supplement Plan, you may call 1-800-621-0839.
- **Short-Term Disability Income Protection** provides up to \$500 or \$1,000 per month to enrollees to replace lost income for a period of 12 or 24 months as a result of a disability due to a covered illness, injury, or complications of pregnancy. The benefit choice and period is up to the enrollee. All enrollees under the age of 60 are guaranteed acceptance in this plan as long as they work at least 30 hours a week. For more information about this program, call 1-800-621-0839.

Benefits on this page are not part of the FEHB contract.

How the Mail Handlers Benefit Plan Changes January 1998

Do not rely on these pages. They are not an official statement of benefits.

Program-wide changes

- This year, the Office of Personnel Management (OPM) instituted minimum benefit levels in all plans for normal deliveries (48 hours of inpatient care), cesarean sections (96 hours of inpatient care), and mastectomies (48 hours of inpatient care). See pages 17–18 for this Plan’s benefits.
- North Dakota will not be included among the states designated as medically underserved in 1998. If you live in North Dakota, this may affect your choice of providers. See page 6 for information on medically-underserved areas.
- Members who are eligible for Medicare Part A benefits for the treatment of End Stage Renal Disease (ESRD) will now be covered by this Plan for the first 30 months of eligibility before Medicare coverage begins. Prior to enactment of the Balance Budget Act of 1997, Medicare picked up these benefits after 18 months.

Changes to this Plan

- The Plan has changed its benefit structure for how it reimburses expenses for inpatient treatment of mental conditions and substance abuse. The \$50,000 annual maximum has been eliminated. Basically, the Plan will now pay benefits (under both options) at 70%, up to 45 days of inpatient care per calendar year, subject to the stated deductible. See page 19 for details.
- The Plan has added a mail order prescription drug benefit for the purchase of certain maintenance medications such as those used to treat chronic conditions like high blood pressure, asthma, and diabetes. See page 26 for details.
- The Plan has added coverage for acupuncture therapy. See page 20 for details.
- The following member copayments/deductibles (the amount you pay) have been changed or will now apply:
 - There is a \$100 per person deductible for certain listed services when you do not use a PPO provider under Standard Option. See pages 21–22 for details.
 - For inpatient medical, surgical or maternity admissions, the deductibles are: no deductible when you use a PPO hospital under High Option, a \$150 deductible when you use a PPO Hospital under Standard Option, a \$250 deductible when you do not use a PPO hospital under High Option, and a \$300 deductible when you do not use a PPO hospital under Standard Option.
 - For surgical facility services, the deductible is \$250 per occurrence when you do not use a PPO facility under High Option and \$300 per occurrence when you do not use a PPO facility under Standard Option. There is no deductible and no coinsurance when you use a PPO facility. There is also a 30% copayment by the member when you do not use a PPO facility. See page 21 for details.
 - There is a \$15 member copayment per office visit, a \$15 member copayment for diagnostic X-rays and machine tests, and a \$5 member copayment for each laboratory test under PPO benefits for both options.
 - There is a \$15 member copayment for each inpatient hospital visit under PPO benefits for both options.
 - There is a \$50 member copayment per occurrence for inpatient and outpatient surgery (including obstetrical care) for both options. See pages 14–15 and 17 for details.
 - There is a \$50 member copayment per occurrence for anesthesia services for both options. See pages 14–15 and 18 for details.
- For prescription drugs purchased from a non-network pharmacy, the Plan will pay 50% of actual charges (after the stated deductible). This charge does not apply to drugs purchased outside the United States. See page 25 for details.
- The Plan will decrease its rate of reimbursement from 75% to 70% for non-PPO High Option benefits under these benefit categories: Other Medical Benefits (except for emergency treatment) on pages 20–22, Maternity Benefits on page 17, and Surgical Benefits on pages 14–15.
- The Plan will require you to pre-authorize purchases for durable medical equipment (DME) in excess of \$1,000 per item. Also, pre-authorization will be required for the rental of DME expected to exceed \$500 per month. Failure to obtain Plan pre-authorization will result in a \$500 penalty to the member.

How the Mail Handlers Benefit Plan Changes January 1998 *continued*

Changes to this Plan *(continued)*

- The Plan has increased the catastrophic protection limit for High Option non-PPO benefits from \$2,000 to \$3,000 per calendar year. Your family's out-of-pocket expenses for non-PPO providers must now reach \$3,000 before the Plan pays benefits at 100% during that calendar year. See page 31 for a complete description of the Plan's catastrophic protection benefit.
- The Plan has added a separate catastrophic protection limit for PPO benefits. The catastrophic limit under High Option is \$2,000 and \$3,000 under Standard Option.
- When Medicare is primary, the Plan will waive the \$100 per person calendar year deductible for certain services under **Standard Option** non-PPO. See page 34.
- When Medicare is primary, the Plan will waive the \$50 copayment for surgery and anesthesia under both options.

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Summary of Standard Option Benefits for the Mail Handlers Benefit Plan — 1998

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. **If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure).** All items below with an asterisk (*) are subject to the \$100 per person calendar year deductible.

		Standard Option pays	Page
Inpatient care	Hospital	PPO benefit: After a \$150 per-admission deductible, 100% of the covered charges.....	13–14
		Non-PPO benefit: After a \$300 per-admission deductible, 100% for room and board and other hospital charges	13–14
	Surgical	PPO benefit: 95% of the covered charges after a \$50 copayment	14–16
		Non-PPO benefit: 70% of the reasonable and customary charges after a \$50 copayment	14–16
	Medical	PPO benefit: 100% of the covered charges after a \$15 copayment	20–23
	Non-PPO benefit: 70%* of the reasonable and customary charges.....	20–23	
	Maternity	Same benefits as illness or injury.....	17–18
	Mental Conditions/ Substance Abuse	PPO benefit: After a \$150 per-admission deductible, 70% of covered charges, up to 45 days per calendar year.....	19
		Non-PPO benefit: After a \$300 per-admission deductible, 70% of covered charges, up to 45 days per calendar year.....	19
Outpatient care	Hospital	PPO: 95% of the covered charges for facility charges related to chemotherapy, hemodialysis, and radiation therapy.....	21
		Non-PPO: 70%* of the reasonable and customary charges for facility charges related to chemotherapy, hemodialysis, and radiation therapy	21
	Surgical	PPO benefit: 95% of the covered charges billed by primary surgeon after a \$50 copayment; 100% of the covered charges billed by surgery facility.....	14–16, 21
		Non-PPO benefit: 70% of the reasonable and customary charges billed by primary surgeon after a \$50 copayment. After a \$300 per-occurrence deductible, 70% of covered charges billed by surgery facility.	14–16, 21
	Medical	PPO benefit: Covered charges paid in full after a \$15 copayment for doctors' medical visits, a \$15 copayment for diagnostic X-rays and a \$5 copayment for laboratory services	20–23
		Non-PPO benefit: 70%* of the reasonable and customary charges for doctors' medical visits and diagnostic X-ray and laboratory services	20–23
	Maternity	Same benefits as illness or injury.....	17–18
	Home Health Care	No current benefit.	
	Mental Conditions/ Substance Abuse	50% of the reasonable and customary charges, limited to 20 visits.....	19
Emergency care (accidental injury)		PPO benefit: 95% of the covered charges, for outpatient treatment of illness or mental conditions/substance abuse; 100% of covered charges for accidental injury within 72 hours of injury	21
		Non-PPO benefit: After a \$50 deductible for illness, 75% of the reasonable and customary charges for outpatient treatment of illness or mental conditions/substance abuse; 100% of the reasonable and customary charges for accidental injury , within 72 hours of injury	21
Prescription drugs		After a \$600 per person calendar year prescription drug deductible, 70% of actual charges for drugs purchased at a PCS participating pharmacy.....	24–26
Dental care		No current benefit.	
Additional benefits		Eyeglasses following accident or surgery, hospice, ambulance, hearing aid following accident, durable medical equipment, home nursing services, orthopedic and prosthetic devices, rabies shots.....	23–24
Catastrophic protection		When an enrollee's out-of-pocket covered expenses for surgical and medical services in a calendar year exceed \$3,000, the Plan will pay 100% of reasonable and customary covered charges during the remainder of the year	31

Summary of High Option Benefits for the Mail Handlers Benefit Plan — 1998

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. **If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure).** This Plan has two options; a summary of benefits for the Standard Option is located on page 45 of this brochure.

		High Option pays	Page
Inpatient care	Hospital	PPO benefit: 100% of covered charges, no deductible13-14 Non-PPO benefit: After a \$250 per-admission deductible, 100% for room and board and other hospital charges13-14	
	Surgical	PPO benefit: 100% of the covered charges after a \$50 copayment14-16 Non-PPO benefit: 70% of the reasonable and customary charges after a \$50 copayment....14-16	
	Medical	PPO benefit: 100% of the covered charges after a \$15 copayment20-23 Non-PPO benefit: 70% of the reasonable and customary charges.....20-23	
	Maternity	Same benefits as illness or injury.....17-18	
	Mental Conditions/ Substance Abuse	PPO benefit: The Plan pays 70% of covered charges up to 45 days per calendar year19 Non-PPO benefit: After a \$250 per-admission deductible, 70% of covered charges up to 45 days per calendar year19	
Outpatient care	Hospital	PPO benefit: 95% of the reasonable and customary charges for facility charges related to chemotherapy, hemodialysis, and radiation therapy21 Non-PPO benefit: 70% of the reasonable and customary charges for facility charges related to chemotherapy, hemodialysis, and radiation therapy21	
	Surgical	PPO benefit: 100% of the covered charges billed by primary surgeon after a \$50 copayment; 100% of the covered charges billed by surgery facility.....14-16, 21 Non-PPO benefit: 70% of the reasonable and customary charges billed by primary surgeon after a \$50 copayment. After a \$250 per-occurrence deductible, 70% of covered charges billed by surgery facility.14-16, 21	
	Medical	PPO benefit: Covered charges paid in full after a \$15 copayment for doctors' medical visits, a \$15 copayment for diagnostic X-rays and a \$5 copayment for each laboratory service.....20-23 Non-PPO benefit: 70% of the reasonable and customary charges for doctors' medical visits and diagnostic X-ray and laboratory services20-23	
	Maternity	Same benefit as illness or injury17-18	
	Home Health Care	No current benefit.	
	Mental Conditions/ Substance Abuse	50% of the reasonable and customary charges, limited to 20 visits per year19	
Emergency care (accidental injury)	PPO benefit: 95% of the covered charges, for outpatient treatment of illness or mental conditions/substance abuse; 100% of covered charges for accidental injury within 72 hours of injury21 Non-PPO benefit: After a \$50 copayment for illness, 75% of the reasonable and customary charges for outpatient treatment of illness or mental conditions/substance abuse; 100% of the reasonable and customary charges for accidental injury , within 72 hours of injury21		
Prescription drugs	After a \$250 per person calendar year prescription drug deductible, 75% of actual charges if purchased at a PCS participating pharmacy24-26		
Dental care	Up to amount stated in the schedule of dental allowances (maximum benefit of \$800 per person, \$1,600 per family each calendar year).....26-28		
Additional benefits	Eyeglasses following accident or surgery, hospice, ambulance, hearing aid following accident, durable medical equipment, home nursing services, orthopedic and prosthetic devices, rabies shots.....23-24		
Catastrophic protection	100% of covered charges when applicable coinsurance reaches \$2,000 per calendar year when PPO providers are used and \$3,000 when they are not.....31		