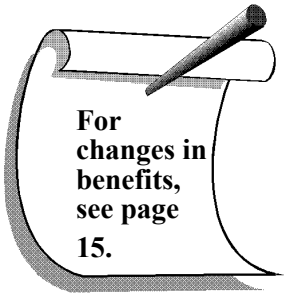
MHBP

www.MHBP.com - 1.800.410.7778

2015

A fee for service plan (Standard Option and Value Plan) with a provider network

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard
for the benefits it provides. See page xxx for details.



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

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

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

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

Enrollment codes for this Plan:

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

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

Coventry Healthcare National Accounts

Other URAC Accreditations:

- Caremark, Inc.: Pharmacy Benefit Management, Drug Therapy Management
- Caremark Rx, LLC: Specialty Pharmacy, Mail Service Pharmacy
- Optum, Houston Care Advocacy: Health Utilization Management

See the 2015 Guide for more information on accreditation.

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 71-007

Important Notice from MHBP About

Our Prescription Drug Coverage and Medicare

The US Office of Personnel Management has determined that the MHBP's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all Plan participants and is considered to be Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your Medicare Part D premium will go up at least 1% per month for each month you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may also have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

MHBP Notice of Privacy Practices

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

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Introduction

This brochure describes the benefits of the Mail Handlers Benefit Plan (MHBP). The National Postal Mail Handlers Union, a division of LIUNA, AFL-CIO, a division of LIUNA, has entered into a contract (CS1146) with the United States Office of Personnel Management as authorized by the Federal Employees Health Benefit law. Customer service may be reached at 1-800-410-7778 and through our website at www.MHBP.com. The address for the administrative offices is:

MHBP
PO Box 8402
London, KY 40742

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2015, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2015, and changes are summarized on pages xxx- xxx. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

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

Stop Health Care Fraud!

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

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

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

- Do not give your Plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-800-410-7778 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/oig

You can write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or material misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining services for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food and other allergies you have, such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- ww.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

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

Never Events

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

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

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

FEHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
Minimum essential coverage (MEC)	Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
Minimum value standard	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
Where you can get information about enrolling in the FEHB Program	See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as: • Information on the FEHB Program and plans available to you • A health plan comparison tool • A list of agencies that participate in Employee Express • A link to Employee Express • Information on and links to other electronic enrollment systems Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you: • When you may change your enrollment; • How you can cover your family members; • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire; • What happens when your enrollment ends; and • When the next Open Season for enrollment begins. We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.
Types of coverage available for you and your family	Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

Family member coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural children, adopted children and stepchildren (including children of same-sex domestic partners in certain states) are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

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

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2015 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2014 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce

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

Temporary Continuation of Coverage (TCC)

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26 regardless of marital status, etc.

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

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

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

Converting to individual coverage

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

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

If you leave Federal or Tribal service, your employing office will notify you of your right to convert. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you.

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

Finding replacement coverage

This Plan no longer offers its own non-FEHB plan for conversion purposes. If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 1-800-410-7778 or visit our website, www.MHBP.com.

Health Insurance Marketplace

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers. We give you a choice of enrollment in Standard Option or Value Plan.

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

General features of our Standard Option and Value Plan

We have Network providers

Our fee-for-service plan offers services through a network of health care providers. When you use Network providers, you will receive covered services at reduced cost. MHBP is solely responsible for the selection of Network providers in your area. Contact us at 1-800-410-7778 for the names of Network providers or to request a Network directory. You can also go to our website, www.MHBP.com.

Continued participation of any specific provider cannot be guaranteed. When you phone for an appointment, please remember to verify that the health care professional or facility is still a Network provider. If your doctor is not currently participating in the provider network, you can nominate him or her to join. Physician nomination forms are available on our website, or call us and we'll have a form sent to you. You cannot change health plans outside of Open Season because of changes to the provider network.

This Plan uses the Coventry Health Care National Network as its provider network in the state of Utah. In all other states, the Network providers are those that participate in the Aetna Choice POS II product. Services from providers outside the continental United States, Alaska and Hawaii will be considered at the Network benefit levels. If you receive non-covered services from a Network provider, the Network discount will not apply and the services will be excluded from coverage. To save both you and the Plan money, we encourage the use of primary care physicians where available and appropriate.

The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no Network provider is available, or you do not use a Network provider, the regular Non-Network benefits apply. The nature of the services (such as urgent or emergency situations) does not affect whether benefits are paid as Network or Non-Network. However, we will provide the Network level of benefits for services you receive from Non-Network anesthesiologists (including Certified Registered Nurse Anesthetists (CRNA)), radiologists, pathologists, co-surgeons and emergency room physicians when inpatient services are provided in a Network hospital and when outpatient surgical and emergency treatment services are provided at a Network facility unless we indicate otherwise. We will also provide the Network level of benefits for services you receive from a Non-Network radiologist related to preauthorized outpatient radiology procedures performed in a Network facility. You will still be responsible for the difference between our allowance and the billed amount.

Network providers for mental health and substance abuse

This Plan has a contract with Optum (formerly United Behavioral Health) to administer our mental health/substance abuse benefits. They have contracts with mental health professionals to provide these services. Network benefits apply only when you use a Network provider. Call us at 1-800-410-7778 for assistance with locating a Network provider. See Section 5(e).

Other Participating Providers

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

How we pay providers

When you use a Network health care provider or facility, our Plan allowance is the negotiated rate for the service. You are not responsible for charges above the negotiated amount for covered services and supplies.

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

If Network providers are available where you receive care and you do not use them, your out-of-pocket expenses will increase. The Plan will base its allowance on a fee schedule that represents an average of the Network fee schedules for a particular service in a particular geographic area (see *Plan allowance*, Section 10, for further details).

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

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

Your Rights

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

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

If you want more information about us, call 1-800-410-7778, or write to: Mail Handlers Benefit Plan, P.O. Box 8402, London, KY 40742. You may also visit our website at www.MHBP.com.

Your medical and claims records are confidential

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

Section 2. Changes for 2015

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

Program-wide changes

Changes to this Plan

- We added coverage for HIV, hepatitis C and sexually transmitted infection screenings when rendered by a network provider. Benefits will be paid at 100% of the Plan's allowance and are not subject to the calendar year deductible. Previously, the Plan had no benefit for these services under preventive care. See *Preventive care, adult*, and *Preventive care, children*, Section 5(a).
- Extended care/skilled nursing care facility benefits are available only when this Plan is the primary payor. Previously, benefits were available when other Plans, excluding Medicare Part A were the primary payor. See *Extended care benefits/ Skilled nursing care facility benefits*, Section 5(c).
- We reclassified coverage of partial hospitalization and facility-based intensive outpatient treatment benefits as outpatient hospital services. Previously, coverage was considered as inpatient hospital. See *Outpatient hospital*, Section 5(e).
- We changed the benefit structure for medications, supplies, and preparatory medications for colorectal cancer screenings. Benefits are available at Network retail pharmacies with no member cost-sharing. Previously, these services required member cost-sharing. See *Covered medications and supplies*, Section 5(f).
- We changed the benefit for specialty oral and self-administered medications to align exclusively under CVS Caremark Specialty Pharmacy. Previously, coverage of specialty oral and self-administered medications dispensed by other than CVS Caremark Specialty Pharmacy was available under the medical benefit. See *Diagnostic and treatment services, Infertility services, Treatment therapies*, Section 5(a) and *Prescription drug benefits*, Section 5(f).
- We added a Specialty Pharmacy Step Therapy Drug Program that requires the use of a specialty preferred drug prior to authorization of a specialty non-preferred drug. Previously, this program was not available. Preauthorization continues to be required for all specialty drugs.

Changes to our Standard Option Only

- Your share of the non-Postal Standard Option Self Only premium will increase. For Standard Option Self and Family your share will increase.
- We combined the catastrophic protection benefit for out-of-pocket medical and prescription drug expenses. Benefits are now available when your out-of-pocket expenses reach $6,000 per person per calendar year, limited to $12,000 per family per calendar year, for covered services and drug expenses from Network providers/facilities and pharmacies, combined; and $9,000 per person per calendar year, limited to $18,000 per family per calendar year, for covered services and drug expenses from Non-Network providers/facilities and pharmacies, combined. See *Your catastrophic protection out-of-pocket maximum*, Section 4.
- We changed the benefit structure for your catastrophic protection out-of-pocket maximum. Out-of-pocket expenses for Network providers and pharmacies will be separate and independent of the out-of-pocket expenses for Non-Network providers. Previously, catastrophic protection out-of-pocket expenses from Network providers and pharmacies accumulated towards the Non-Network limit. See *Your catastrophic protection out-of-pocket maximum*, Section 4.
- We have ceased offering the Part B Premium Savings Program for Standard Option members. See *When you have Medicare*, Section 9.

Changes to our Value Plan Only

- Your share of the non-Postal Value Plan Self Only premium will increase. For Value Plan Self and Family your share will increase.

- We combined the catastrophic protection benefit for out-of-pocket medical and prescription drug expenses. Benefits are now available when your out-of-pocket expenses reach $6,750 per person per calendar year, limited to $13,500 per family per calendar year, for covered services and drug expenses from Network providers/facilities and pharmacies, combined; and $10,000 per person per calendar year, limited to $20,000 per family per calendar year, for covered services of Non-Network providers/facilities. See *Your catastrophic protection out-of-pocket maximum*, Section 4.
- We changed the benefit structure for your catastrophic protection out-of-pocket maximum. Out-of-pocket expenses for Network providers and pharmacies will be separate and independent of the out-of-pocket expenses for Non-Network providers. Previously, catastrophic protection out-of-pocket expenses from Network providers and pharmacies accumulated toward the Non-Network limit. See *Your catastrophic protection out-of-pocket maximum*, Section 4.
- We reduced the Network copayment visits to a convenient care clinic by dependent children through age 21 to $5 per visit. Previously, the copayment for visits to a Network convenient care clinic was $15 per visit for all members. See *Diagnostic and treatment services*, Section 5(a).
- We removed the requirement that the calendar year deductible must be met before benefits are available for emergency treatment of an accidental injury at a Network urgent care center. Previously, the calendar year deductible had to be met before Plan benefits were available. See *Accidental injury*, Section 5(d).

Clarifications

- We clarified that any qualified, licensed medical professional practicing within the scope of their state-issued license or certification is considered to be a covered provider. See *Where you get covered care*, Section 3.
- We clarified that residential treatment facilities are considered to be covered facilities when preauthorized. See *Where you get covered care*, Section 3.
- We clarified the standards/criteria for determining Plan approval of precertification requests. See *You need prior Plan approval for certain services*, Section 3.
- We clarified the preauthorization requirements for transplants and related services. See *You need prior Plan approval for certain services*, Section 3.
- We clarified that routine immunizations are covered at 100%, but other services provided during the visit may have cost-sharing. See *Preventive care, adult* and *Preventive care, children*, Section 5(a).
- We clarified that flu vaccines are covered at 100%, but other services provided during the visit may have cost-sharing. See *Preventive care, adult* and *Preventive care, children*, Section 5(a).
- The name of the transplant network has changed from Coventry Transplant Network to Aetna Institutes of Excellence. See *Organ/tissue transplants*, Section 5(b).
- We clarified that outpatient hospital benefits will be applied when non-emergency care is provided in a hospital emergency room. See *Outpatient hospital or ambulatory surgical center*, Section 5(c).
- We clarified that transportation to or from services are only covered as part of covered inpatient hospital care. See *Ambulance*, Sections 5(c) and 5(d).
- We added a preauthorization requirement for extended outpatient treatment visits. See *Mental health and substance abuse benefits*, Section 5(e).
- We clarified that treatment for binge eating disorder and gambling disorder are not covered. See *Mental health and substance abuse benefits*, Section 5(e).
- We clarified that the preferred drug category is also called formulary and that the non-preferred drug category is also called non-formulary. See *Prescription drug benefits*, Section 5(f).
- We changed the benefit for specialty drugs. Oral and self-administered specialty drugs may only be obtained through our CVS Caremark Specialty Program. See *Prescription drug benefits*, Section 5(f).
- We added a description of the flu vaccine program to *Covered medications and supplies*, Section 5(f).

Section 3. How you get benefits

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-410-7778 or write to us at MHBP, PO Box 8402, London, KY 40742. You may also request replacement cards through our website: www.MHBP.com.

Where you get covered care

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

- **Covered providers**

We provide benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act (PHSA). Coverage of practitioners is not determined by your state's designation as a medically underserved area (MUA).

Covered professional providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

- **Covered facilities**

Covered facilities include:

Freestanding ambulatory facility. A facility that meets the following criteria:

1. has permanent facilities and equipment for the primary purpose of performing surgical and/or renal dialysis procedures on an outpatient basis;
2. provides treatment by or under the supervision of doctors and nursing services whenever the patient is in the facility;
3. does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a doctor or other professional.

The Plan will apply its outpatient surgical facility benefits only to facilities that have been accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), the Accreditation Association for Ambulatory Health Care (AAAHC), or that have Medicare certification as an ASC facility.

Network providers. The Plan may approve coverage of providers who are not currently shown as Covered providers to provide mental health/substance abuse treatment under the Network benefit. Coverage of these providers is limited to circumstances where the Plan has approved the treatment plan.

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

1. general inpatient acute care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which must be provided on its premises or under its control; or
2. specialized inpatient acute medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises or under its control, or through a written agreement with a hospital or with a specialized provider of those facilities; or
3. a licensed birthing center.

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

1. is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged; or
2. furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or
3. is operated as a school; or
4. is operated as a residential treatment facility regardless of its State licensure or accreditation status, unless preauthorized and approved under mental health and substance abuse benefits.

Residential treatment facility. A facility that provides a program of effective mental health or substance use disorder services/treatment and which meets all of the following requirements:

1. is established and operated in accordance with applicable state law for residential treatment programs;
2. provides a program of treatment under the active participation and direction of a licensed physician who is practicing within the scope of the physician's license;
3. has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient;
4. provides at least the following basic services in a 24-hour per day, structured milieu;
   - Room and board
   - Evaluation and diagnosis
   - Counseling
   - Referral and orientation to specialized community resources

Preauthorization is required.

Christian Science nursing facility. A facility which is approved by the Commission for the Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Skilled nursing care facility. An institution or that part of an institution, which provides convalescent skilled nursing care 24-hours-a-day and is classified as a skilled nursing care facility under Medicare.

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.

Transitional care

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

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

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

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

If you are hospitalized when your enrollment begins

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

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

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

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

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, prior approval or a referral and (2) will result in a reduction of benefits if you do not obtain precertification, prior approval or a referral.

We make our determination based on nationally recognized clinical guidelines and standard criteria sets. These determinations can affect what we pay on a claim.

- **Inpatient hospital admission**

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

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us and that we have approved the admission.

- Warning

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

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

- If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.
- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will pay 70% (Standard Option) or 60% (Value Plan) for covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay room and board inpatient hospital benefits. We will pay 70% (Standard Option) or 60% (Value Plan) for covered medical services and supplies that are otherwise payable on an outpatient basis.

If you remain in the hospital beyond the number of days we approved and you do not get the additional days precertified, then:

- we will pay inpatient benefits for the part of the admission that we determined was medically necessary, but
- we will pay 70% (Standard Option) or 60% (Value Plan) of the covered medical services and supplies otherwise payable on an outpatient basis and will not pay room and board benefits for the part of the admission that was not medically necessary.

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

- Exceptions

You do not need precertification in these cases:

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

- **Outpatient imaging procedures**

We require preauthorization for the following outpatient radiology/imaging services:

- CT/CAT scan – Computed Tomography/Computerized Axial Tomography
- CTA – Computed Tomography Angiography
- MRA – Magnetic Resonance Angiography
- MRI – Magnetic Resonance Imaging
- NC – Nuclear Cardiac Imaging
- PET – Positron Emission Tomography
- SPECT – Single-Photon Emission Computerized Tomography

You, your representative or your physician must contact us at least two working days prior to scheduling the outpatient imaging procedures listed above. We will evaluate the medical necessity of your proposed procedure to ensure it is appropriate for your condition. See *How to request precertification for an admission or get preauthorization for Other services*, below.

In most cases, your physician will take care of preauthorization. Because you are still responsible for ensuring that your procedure is preauthorized, you should always ask your physician whether they have contacted us and that we have approved the procedure.

When possible, arranging to have the imaging procedures listed above performed at a Network stand-alone imaging center will help you to maximize your benefits.

See *Lab, X-ray and other diagnostic tests*, Section 5(a).

- Warning — We will reduce our benefits by $100 per occurrence if no one contacts us for preauthorization. If preauthorization is denied, we will not pay any benefits.

- Exceptions — You do not need preauthorization in these cases:
  - The procedure is performed outside the United States.
  - You have other group health insurance coverage that is the primary payor, including Medicare.
  - The procedure is performed in an emergency situation.
  - You have been admitted to a hospital on an inpatient basis.

- **Other services** — Some services require preauthorization or precertification before we will consider them for benefits. Preauthorization must be obtained two business days in advance of the planned service or procedure. Call us at 1-800-410-7778 as soon as the need for these services is determined.
  - We require preauthorization for genetic testing. See Section 5(a).
  - We require preauthorization for chelation therapy. See Section 5(a).
  - We require preauthorization for hyperbaric oxygen therapy. See Section 5(a).
  - We require preauthorization for certain oncology and specialty drugs administered by a physician in an outpatient setting, including specialty oral and self-administered drugs, such as growth hormones and drugs to treat multiple sclerosis and infertility. A list of drugs requiring preauthorization is available on the Plan's website and by calling us. See Section 5(a) and 5(f).
  - We require preauthorization for audible prescription reading devices. See Section 5 (a).
  - We require preauthorization for spinal surgery. See Section 5(b).
  - We require preauthorization for surgical treatment of morbid obesity (bariatric surgery).
    See Section 5(b).
  - We require preauthorization of transplants and transplant-related services, except corneal transplants, even when other coverage, including Medicare, is your primary payor for health benefits. You or your physician must call 1-800-410-7778 to speak with a transplant case manager prior to your pre-transplant evaluation as a potential candidate for a transplant procedure. See Section 5(b).
  - We require preauthorization for pain management services. See section 5(b).
  - We require preauthorization for care in a skilled nursing facility. See Section 5(c).
  - We require preauthorization for Vagus nerve stimulation therapy. See Section 5(e).
  - We require preauthorization for extended outpatient treatment visits, outpatient intensive therapy, partial hospitalization and electroshock/electroconvulsive therapy. See Section 5(e).
  - We require preauthorization for outpatient psychological and neuropsychological testing. See Section 5(e).
  - We require a brand exception for brand name drugs when a generic equivalent is available. See Section 5(f).
  - We require preauthorization of certain classes of drugs including, but not limited to, human growth hormone (HGH). See Section 5(f).
  - We require precertification when you have Medicare Part B only as your primary payor for an outpatient hospitalization that exceeds 23 hours and results in hospital admission.

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

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

We can help you understand your benefits and locate a Network provider.

- **Organ/tissue transplants**

We require preauthorization for all organ/tissue transplant procedures and related services (except cornea). This requirement applies even when other coverage, including Medicare, is your primary payor for health benefits.

You, your representative, the doctor, or the hospital must contact us before your evaluation as a potential candidate for a transplant procedure so we can arrange to review the evaluation results and determine whether the proposed procedure is approved for coverage. You must have our written approval for the procedure before the Plan will cover any transplant-related expenses.

In most cases, your physician will take care of preauthorization. Because you are still responsible for ensuring that this requirement is met, you should always confirm that your physician has contacted us and that we have approved the procedure.

- Warning

We will not pay any benefits if no one contacts us for preauthorization or if preauthorization is denied.

- Exceptions

You do not need preauthorization in these cases:

- Corneal transplants.
- Transplant procedures performed outside the United States.

How to request precertification for an admission or get preauthorization for other services

First, you, your representative, your physician, or your hospital must call us at 1-800-410-7778 before admission or services requiring preauthorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

- **Non-urgent care claims**

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim.

If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

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

- **Urgent care claims**

If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-410-7778. You may also call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-800-410-7778. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

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

- **If your hospital stay needs to be extended**

If your hospital stay – including for maternity care – needs to be extended, you, your representative, your doctor or the hospital must contact us for precertification of the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

- For the part of the admission that was medically necessary, we will pay inpatient benefits, but
- For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

- **If your treatment needs to be extended**

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.
   You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
   If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

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

Cost sharing

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

Copayment

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

Example: When you have Standard Option and see your primary care Network physician you pay a copayment of $20 per visit for adult members or $10 per visit for dependent children through age 21.

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

Deductible

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

- The Standard Option calendar year deductible for covered services and supplies is $400 per person, limited to $800 per family, for services received from Network providers, and $600 per person, limited to $1,500 per family, for services received from Non-Network providers.
- The Value Plan calendar year deductible for covered services and supplies is $600 per person, limited to $1,200 per family, for services received from Network providers, and $900 per person, limited to $1,800 per family, for services received from Non-Network providers.

Under a family enrollment, the calendar year deductible is satisfied for all family members when the combined covered expenses applied to the deductible for all family members reach the respective per family limit.

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

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

Note: If you change plans or plan options during Open Season and the effective date of your new plan or plan option is after January 1 of the next year, you do not have to start a new deductible under your old plan or plan option between January 1 and the effective date of your new plan or plan option. If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

Example: You pay 30% of our allowance under Standard Option and 40% of our allowance under Value Plan for Non-Network office visits.

If your provider routinely waives your cost

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

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

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

Waivers

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

Differences between our allowance and the bill

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

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

- **Network providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is a Standard Option example: You see a Network physician for an office visit who charges $150, but our allowance is $100. You are only responsible for your copayment. That is, you pay just $20 of our $100 allowance for an adult office visit. Because of the agreement, your Network physician will not bill you for the $50 difference between our allowance and his/her bill.
- **Non-Network providers**, on the other hand, have no agreement to limit what they will bill you. When you use a Non-Network provider, you will pay your deductible and coinsurance – **plus** any difference between our allowance and charges on the bill. Here is a Standard Option example: You see a Non-Network physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the Non-Network physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill. For details on how we determine the Plan allowance, please see Section 10.
- **Participating providers** agree to limit what they can collect from you. You will still have to pay your deductible and coinsurance. These providers agree to write off the difference between billed charges and the discount amount.

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

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

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

Your catastrophic protection out-of-pocket maximum

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

Standard Option

- $6,000 per person per calendar year; $12,000 per family per calendar year, for covered services and drugs from Network providers/facilities and pharmacies, combined
- $9,000 per person per calendar year; $18,000 per family per calendar year, for covered services and drugs from Non-Network providers/facilities and pharmacies, combined

Value Plan

- $6,750 per person per calendar year; $13,500 per family per calendar year, for covered services and drugs from Network providers/facilities and pharmacies, combined
- $10,000 per person per calendar year; $20,000 per family per calendar year, for covered services of Non-Network providers/facilities

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

- Expenses in excess of the Plan allowance or maximum benefit limitations
- Expenses for non-covered services, drugs and supplies
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see *You need prior Plan approval for certain services*, Section 3)
- The difference in cost between a brand name drug and the generic equivalent

Carryover

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

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

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

If we overpay you

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

When Government facilities bill us

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

Section 5. Standard Option and Value Plan Benefits

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

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

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

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $400 per person ($800 per family) for services of Network providers and $600 per person ($1,500 per family) for services of Non-Network providers.
  - The Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of Network providers and $900 per person ($1,800 per family) for services of Non-Network providers.
- The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. When no Network provider is available, Non-Network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost - sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.
- YOU MUST GET PREAUTHORIZATION FOR CERTAIN OUTPATIENT IMAGING PROCEDURES. FAILURE TO DO SO WILL RESULT IN A MINIMUM $100 PENALTY PER OCCURRENCE.
  Please refer to the preauthorization procedures in Section 3.

Benefit Description	You pay After the calendar year deductible...	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Diagnostic and treatment services	**Standard Option**	**Value Plan**
Professional services of a primary care physician (limited to: general practitioner, family practitioner, internist, pediatrician, physician's assistant and nurse practitioner)	Network: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: $30 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Christian Science practitioners	Same as above	Same as above
Professional services of specialists: • In physician's office (this includes evaluation and management services related to chemotherapy, hemodialysis and radiation therapy) • At home • Office medical consultations • Second surgical opinions provided in a physician's office	Network: $40 copayment per office visit (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: $50 copayment per office visit Non-v: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Diagnostic and treatment services (cont.)	**Standard Option**	**Value Plan**
Note: See Section 5(b) for professional services related to surgery. Note: See *Prescription drug benefits*, Section 5 (f) for related drug coverage. Certain specialty drugs, oncology drugs and growth hormones require preauthorization; see *Specialty drugs*, Section 5(f), and *Other services* under *You need prior Plan approval for certain services,* Section 3.	Network: $40 copayment per office visit (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: $50 copayment per office visit Non-v: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Note: When you receive both a comprehensive preventive evaluation and management (E/M) service and a problem-oriented E/M service during the same office visit, the Plan's benefit is determined as follows: • For the comprehensive preventive care service: - Network: the Plan's full allowance, or - Non-Network: the Plan's full allowance • For the problem-oriented service: - Network: one-half of the Plan's allowance, unless the Network contract provides for a different amount - Non-Network: one-half of the Plan's allowance		
Same-day services (such as lab tests) performed and billed in conjunction with the office visit (except allergy shots, rabies shots or routine immunizations)	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Professional non-emergency services provided in a convenient care clinic (see Definitions, Section 10). For services related to an accidental injury or medical emergency, see Section 5(d).	Network: $5 copayment per visit (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: $15 copayment per visit for adults (No deductible); $5 copayment per visit for dependent children through age 21 (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Professional services of physicians during a hospital stay	Network: 10% of the Plan's allowance	Network: 20% of the Plan's allowance

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Diagnostic and treatment services (cont.)	**Standard Option**	**Value Plan**
Note: Outpatient cancer treatment (chemotherapy, X-rays, or radiation therapy) and dialysis services are paid under Section 5 (a) *Treatment therapies.*	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Routine physical checkups and related tests, except those covered under preventive care* • *Thermography and related visits* • *Chelation therapy and related services, except as part of a preauthorized treatment plan that we have approved* • *Orthoptic visits and related services* • *Telephone and internet-based consultations*	*All charges*	*All charges*
Lab, X-ray and other diagnostic tests	**Standard Option**	**Value Plan**
Non-routine tests, such as: • Blood tests • Urinalysis Note: Urine drug testing/screening is covered only as described in "FEHBP Urine Drug Testing Coverage", available on our Web site, www.MHBP.com, and by calling us at 1-800-410-7778. • Pap tests • Pathology • X-rays • Mammograms • CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT, provided in the outpatient department of a hospital Note: Preauthorization for these procedures is required. Call us at 1-800-410-7778 prior to scheduling. See *Outpatient imaging procedures* under *You need prior Plan approval for certain services*, Section 3. • Ultrasound • Electrocardiogram and EEG	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your Network provider uses a Non-Network lab or radiologist, we will pay Non-Network benefits for any lab and X-ray charges.	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount Note: If your Network provider uses a Non-Network lab or radiologist, we will pay Non-Network benefits for any lab and X-ray charges.
• CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT, provided at a stand-alone imaging center or clinic	Network: Nothing	Network: Nothing

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

Benefit Description	You pay After the calendar year deductible...	
Lab, X-ray and other diagnostic tests (cont.)	**Standard Option**	**Value Plan**
Note: Preauthorization for these procedures is required. Call us at 1-800-410-7778 prior to scheduling. See *Outpatient imaging procedures* under *You need prior Plan approval for certain services,* Section 3. Note: Call us at 1-800-410-7778 for details about coverage and information about stand-alone imaging centers.	Network: Nothing Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: Expenses for related professional services are covered under this benefit.	Network: Nothing Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount Note: Expenses for related professional services are covered under this benefit.
Genetic testing Note: Preauthorization for genetic testing is required. Call us at 1-800-410-7778. See *Other services* under *You need prior Plan approval for certain services*, Section 3.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program You can use this voluntary program for covered lab tests. You show your MHBP identification card and ask your doctor to send your lab order to Quest Diagnostics. As long as Quest Diagnostics does the testing and bills us directly, you will not have to file any claims. To find a location near you, call 1-800-377-7220, or visit our Web site at www.mhbp.com.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services provided by a physician or lab tests performed by an associated facility not participating in the Lab Savings Program are subject to applicable deductibles, copayments and coinsurance.	Nothing (No deductible) Note: This benefit applies to expenses for lab tests only. Related expenses for services provided by a physician or lab tests performed by an associated facility not participating in the Lab Savings Program are subject to applicable deductibles, copayments and coinsurance.
Not covered: • *Handling and administrative charges* • *Routine lab services except as covered under Preventive care* • *Professional fees for automated tests* • *Genetic screening (See Definitions, Section 10)* • *Salivary hormone testing for other than the diagnosis of Cushing's syndrome*	*All charges*	*All charges*
Preventive care, adult	**Standard Option**	**Value Plan**
Routine physical examination – one per calendar year for members age 18 and older, limited to: • Patient history and risk assessment • Basic metabolic panel • General health panel Note: Please contact us to obtain information on the specific tests covered under this benefit.	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**Standard Option**	**Value Plan**
Note: When you receive both a comprehensive preventive evaluation and management (E/M) service and a problem-oriented E/M service during the same office visit, you are responsible for paying your cost-share for the non-preventive services. See *Diagnostic and treatment services*, Section 5(a).	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges
Routine screenings, including related office visits, limited to: • Mammogram for women age 35 and older: - From age 35 to 39 – one during this five year period - At age 40 and older – one per calendar year • Pap test – one per calendar year • HPV (human papillomavirus) test – one per calendar year • Prostate specific antigen (PSA) test – one per calendar year for men age 40 and older • Colorectal cancer screening, including: - Fecal occult blood (stool) test — one per calendar year for members age 40 and older - Screening sigmoidoscopy — one every two consecutive calendar years for members age 50 and older - Colonoscopy – one every 10 years for members age 50 and older • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members • Body mass index testing – one per calendar year for all members • Chlamydial infection screening • Osteoporosis screening (bone density study) one every two consecutive calendar years for members age 50 and older • Abdominal aortic aneurysm screening – one per lifetime for men age 65 to 75	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount Note: Expenses for anesthesia and outpatient facility services related to covered colorectal cancer screening are covered under this benefit.	Network: Nothing (No deductible) Non-Network: All charges Note: Expenses for anesthesia and outpatient facility services related to covered colorectal cancer screening are covered under this benefit.
Women's preventive care – one per calendar year including, but not limited to: • Well-woman exam	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges

Preventive care, adult - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, adult (cont.)	**Standard Option**	**Value Plan**
• Human immune-deficiency virus (HIV) screening and counseling– one per calendar year • Counseling for sexually transmitted infections • Screening and counseling for interpersonal and domestic violence	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) Note: This benefit covers the immunication only.	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	Network: Nothing (No deductible) Non-Network: All charges
Flu vaccines obtained from a participating network provider Note: This benefit covers the flu vaccine only. Note: See *Prescription drug benefits*, Section 5 (f) to find a participating network pharmacy in the Flu Vaccination Program.	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges
Note: A complete list of preventive care services recommended under the USPSTF is available online at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.		
Not covered: • *Routine physical checkups and related tests except those listed above.* • *Routine physical checkups and related tests provided in an urgent care setting* • *Flu vaccines obtained from a non-participating provider*	*All charges*	*All charges*
Preventive care, children	**Standard Option**	**Value Plan**
Routine childhood immunizations recommended by the American Academy of Pediatrics Note: This benefit covers the immunization only.	Network: Nothing (No deductible) Non-Network: The difference between our allowance and the billed amount (No deductible)	Network: Nothing (No deductible) Non-Network: All charges
Flu vaccines obtained from a participating network provider Note: This benefit covers the flu vaccine only. Note: *See Prescription drug benefits*, Section 5 (f) to find a participating network pharmacy in the Flu Vaccination Program.	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges

Preventive care, children - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Preventive care, children (cont.)	**Standard Option**	**Value Plan**
Well-child office visits to a doctor for covered dependent children through age 17 Note: This benefit covers the office visit only, not any related services. Note: When you receive both a comprehensive preventive evaluation and management (E/M) service and a problem-oriented E/M service during the same office visit, you are responsible for paying your cost-share for the non-preventive services. See *Diagnostic and treatment services*, Section 5(a).	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: All charges
Routine screenings, limited to: • Blood cholesterol – one per calendar year for all members • Urinalysis – one per calendar year for all members • Body mass index testing - one per calendar year for all members	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: All charges
Retinal screening exam for low birth weight premature infants as recommended by the American Academy of Pediatrics	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: All charges
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm and HHS: www.healthcare.gov/prevention IOM: http://www.iom.edu/Reports/2011/Early-Childhood-Obesity-Prevention-Policies/Recommendations.aspx AAP: http://www2.aap.org/immunization/pediatricians/pediatricians.html CDC: http://www.cdc.gov/nccdphp/dnpao/hwi/resources/preventative_screening.htm		
Not covered: • *Routine testing not specifically listed as covered* • *Routine physical checkups and related tests provided in an urgent care setting* • *Flu vaccines obtained from a non-participating provider*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Maternity care	**Standard Option**	**Value Plan**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Anesthesia • Postnatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk Note: Here are some things to keep in mind: • You do not need to precertify your admission for a normal delivery. See *How to get approval for...* in Section 3 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital/birthing center up to 48 hours after your admission for a regular delivery and 96 hours after your admission for a cesarean delivery (you do not need to precertify the normal length of stay). We will cover an extended stay for you or your baby if medically necessary, but you, your representative, your doctor, or your hospital must precertify the extended stay. See *How to request precertification for an admission or get prior authorization for Other services* in Section 3 for other circumstances. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • The initial newborn exam is payable under this benefit. • We cover circumcision under *Surgical procedures*, Section 5(b). • We cover expenses for inpatient and outpatient hospital services under Section 5 (c). • Newborn charges incurred as a result of illness, are considered expenses of the child, not the mother, and are subject to a separate precertification and separate coinsurance and/or copayments.	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Maternity care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Maternity care (cont.)	**Standard Option**	**Value Plan**
• Maternity benefits will be paid at the termination of pregnancy. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation. Note: IV/infusion therapy and injections for treatment of complications of pregnancy are covered under *Treatment therapies*, Section 5 (a).	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
• Breastfeeding counseling during pregnancy and/or postpartum period • Breastfeeding equipment rental or purchase Note: We limit our benefit for the rental of breastfeeding equipment to an amount no greater than what we would have paid if the equipment had been purchased. We will only cover the cost of standard equipment. Note: Call us at 1-800-410-7778 after your last trimester of pregnancy begins and submit your physician's order. We can provide additional coverage details and information about Network providers.	Network: Nothing (No deductible) Non-Network: All charges	Network: Nothing (No deductible) Non-Network: All charges
Not covered: • Standby doctors • Home uterine monitoring devices • Services provided to the newborn if the infant is not covered under a self and family enrollment	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Family Planning	**Standard Option**	**Value Plan**
Voluntary family planning services, including patient education and counseling, limited to: • Voluntary sterilization for women (including related expenses for anesthesia and outpatient facility services, if necessary) • Surgically implanted contraceptives (including related expenses for anesthesia and outpatient facility services, if necessary) • Intrauterine devices (IUDs) • Injectable contraceptive drugs (such as Depo-Provera) Note: We cover other women's contraceptive drugs and devices under *Prescription drug benefits*, Section 5(f). Note: We cover voluntary sterilization for men under *Surgical procedures*, Section 5(b).	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
• Injectable contraceptive drugs (such as Depo-Provera) Note: We cover the related office visit under *Diagnostic and treatment services*, Section 5(a). Note: We cover oral contraceptive drugs under *Prescription drug benefits*, Section 5(f).	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Preimplantation genetic diagnosis (PGD)* • *Genetic counseling* • *Genetic screening*	*All charges*	*All charges*
Infertility services	**Standard Option**	**Value Plan**
Diagnosis and treatment of infertility, except as shown in *Not covered.* Note: See *Prescription drug benefits*, Section 5 (f) for related drug coverage. Certain specialty drugs, oncology drugs and growth hormones require preauthorization; see *Specialty drugs*, Section 5(f), and *Other services* under *You need prior Plan approval for certain services,* Section 3.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:*	*All charges*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Infertility services (cont.)	**Standard Option**	**Value Plan**
- *artificial insemination* - *in vitro fertilization* - *embryo transfer and gamete intra-fallopian transfer (GIFT)* - *intravaginal insemination (IVI)* - *intracervical insemination (ICI)* - *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm or egg* • *Sperm bank collection and storage fees* • *Surrogacy (host uterus/gestational carrier)*	*All charges*	*All charges*
Allergy care	**Standard Option**	**Value Plan**
Evaluation and treatment services, provided in a doctor's office	Network: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: $50 copayment per office visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Testing, including materials	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Allergy serum	Network: $5 copayment (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Allergy injections (not including the serum)	Network: $5 copayment per visit (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered:	*All charges*	*All charges*

Allergy care - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Allergy care (cont.)	**Standard Option**	**Value Plan**
• *Any services or supplies considered by the National Institute of Health and the National Institute of Allergy and Infectious Disease to be not effective to diagnose allergies and/or not effective in preventing an allergy reaction* • *Provocative food testing and sublingual allergy desensitization* • *Clinical ecology and environmental medicine*	*All charges*	*All charges*
Treatment therapies	**Standard Option**	**Value Plan**
• Chemotherapy and radiation therapy for treatment of cancer. Note: Call us at 1-800-410-7778 for details about coverage and information about chemotherapy treatments and Network providers. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under *Organ/tissue transplants*, Section 5(b). • Hyperbaric oxygen therapy • Treatment room • Observation room Note: These therapies (excluding the related office visits) are covered under this benefit when billed by the outpatient department of a hospital, clinic or a physician's office. Pharmacy charges for chemotherapy drugs (including prescription drugs to treat the side effects of chemotherapy) are covered under *Prescription drug benefits*, Section 5(f). Note: Preauthorization is required for hyperbaric oxygen therapy. Call us at 1-800-410-7778 prior to scheduling treatment. See *Other services* under *You need prior Plan approval for certain services*, Section 3. Note: See *Prescription drug benefits*, Section 5(f) for related drug coverage. Certain specialty drugs, oncology drugs and growth hormones require preauthorization; see *Specialty drugs*, Section 5(f), and *Other services* under *You need prior Plan approval for certain services,* Section 3.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Treatment therapies (cont.)	**Standard Option**	**Value Plan**
• Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy, including TPN • Respiratory therapy • Inhalation therapy • Growth hormone therapy Note: Call us at 1-800-410-7778 for details about coverage and information about dialysis, IV/infusion therapy, respiratory therapy and inhalation therapy Network providers. Note: These therapies (excluding the related office visits) are covered under this benefit when performed on an outpatient basis. Note: See *Prescription drug benefits*, Section 5 (f) for related drug coverage. Certain specialty drugs, oncology drugs and growth hormones require preauthorization; see *Specialty drugs*, Section 5(f), and *Other services* under *You need prior Plan approval for certain services,* Section 3.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Rabies shots and related services	Nothing (No deductible)	Nothing (No deductible)
Not covered: • *Chelation therapy and related services, except as part of a preauthorized treatment plan that we have approved* • *Chemotherapy supported by a bone marrow transplant or with stem cell support for any diagnosis not listed as covered under Section 5(b)* • *Topical hyperbaric oxygen therapy* • *Prolotherapy* • *Applied behavioral analysis (ABA) therapy*	*All charges*	*All charges*
Physical, occupational and speech therapies	**Standard Option**	**Value Plan**
Outpatient physical therapy, speech therapy, and occupational therapy	Network: 10% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined therapies maximum	Network: 20% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined therapies maximum

Physical, occupational and speech therapies - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Physical, occupational and speech therapies (cont.)	**Standard Option**	**Value Plan**
Note: The 26-visit per person combined therapies annual maximum for physical, occupational, and speech therapy, chiropractic care and alternative treatments includes all covered services and supplies billed for these therapies. When more than one type of therapy, for example physical therapy and speech therapy, are provided on the same day, each will be counted as a separate visit. Note: For the purposes of this benefit, services and supplies provided by a doctor of osteopathy (D.O.) are included in the 26-visit per person annual benefit maximum. Note: Medically necessary outpatient physical or occupational therapy provided by a skilled nursing facility (SNF) is covered under this benefit if you are not confined in the SNF.	Network: 10% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined therapies maximum Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid the 26-visit combined therapies maximum	Network: 20% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined therapies maximum Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid the 26-visit combined therapies maximum
Not covered: • *All charges after the Plan has paid the 26-visit per person combined therapies annual maximum* • *Exercise programs* • *Outpatient pulmonary rehabilitation* • *Outpatient cardiac rehabilitation programs* • *Massage therapy*	*All charges*	*All charges*
Hearing services (testing, treatment, and supplies)	**Standard Option**	**Value Plan**
Hearing exam and testing: • Routine – one per calendar year • Non-routine Note: For coverage of hearing aids, see *Orthopedic and prosthetic devices*, page xxx	Network: Nothing (No deductible) Non-Network: Any difference between our allowance and the billed amount (calendar year deductible applies)	Network: Nothing (No deductible) Non-Network: Any difference between our allowance and the billed amount (calendar year deductible applies)
Vision services (testing, treatment, and supplies)	**Standard Option**	**Value Plan**
One pair of eyeglasses or contact lenses to correct an impairment directly caused by an accidental ocular injury or intraocular surgery (such as for cataracts). The eyeglasses or contact lenses must be purchased within one year of the injury or surgery and the patient must be covered by the Plan at the time of purchase.	All charges over $50 for one set of eyeglasses or $100 for contact lenses, including examination (No deductible)	Network: All charges over $50 for one set of eyeglasses or $100 for contact lenses, including examination (No deductible) Non-Network: 40% of the Plan's allowance and all charges over $50 for one set of eyeglasses or $100 for contact lenses, including examination (calendar year deductible applies)

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Vision services (testing, treatment, and supplies) (cont.)	**Standard Option**	**Value Plan**
Not covered • *All charges after the Plan has paid the $50 (eyeglasses) or $100 (contact lenses) benefit maximum* • Routine eye exams and related office visits • *Eyeglasses, contact lenses and examinations not directly related to an ocular injury or intraocular surgery* • *Eye exercises* • *Refractions* • *Radial keratotomy including laser keratotomy and other refractive surgery*	*All charges*	*All charges*
Foot care	**Standard Option**	**Value Plan**
Professional services for routine foot care for established diabetics only. For medically necessary surgeries, see *Surgical procedures*, Section 5(b).	Network: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible); 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: $50 copayment per office visit Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: *Cutting, trimming and removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except for the established diagnosis of diabetes*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**Standard Option**	**Value Plan**
Orthopedic and prosthetic devices (see *Definitions*, Section 10) when recommended by an MD or DO, including: • Artificial limbs and eyes • Stump hose • Custom constructed braces • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy	Network: 10% of the Plan's allowance Non-Network: 10% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices (cont.)	**Standard Option**	**Value Plan**
• Internal prosthetic devices such as cochlear implants, bone anchored hearing aids (BAHA), artificial joints, pacemakers and breast implants following mastectomy, if billed by other than a hospital Note: Call us at 1-800-410-7778 for details about coverage and information about orthopedic and prosthetic Network providers. Note: We will only cover the cost of a standard item. Coverage for specialty items such as bionics is limited to the cost of the standard item. Note: For benefit information related to the professional services for the surgery to insert an internal device, see *Surgical procedures*, Section 5(b). For benefit information related to the services of a hospital and/or ambulatory surgery center, see Section 5(c).	Network: 10% of the Plan's allowance Non-Network: 10% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Hearing aids – one hearing aid per ear every five (5) calendar years.	Network: All charges over $500, up to the Plan's allowance, for one hearing aid per ear (No deductible) Non-Network: All charges over $500 for one hearing aid per ear (No deductible)	Network: All charges over $500, up to the Plan's allowance, for one hearing aid per ear (No deductible) Non-Network: All charges over $500 for one hearing aid per ear (No deductible)
Not Covered: • *Orthopedic and corrective shoes unless attached to a brace, arch supports, heel pads and heel cups, foot orthotics and related office visits* • *Lumbosacral supports, corsets, trusses, elastic stockings, support hose, non-custom hinged knee braces and other supportive devices* • *Compression/support sleeves, except for treatment of lymphedema and severe burns* • *Prosthetic replacements provided less than 3 years after the last one we covered unless a replacement is needed for medical reasons* • *Penile prosthetics* • *Customization or personalization beyond what is necessary for proper fitting and adjustment of the items*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Orthopedic and prosthetic devices (cont.)	**Standard Option**	**Value Plan**
• *Hearing aid replacements within five years after the last one we covered; replacement batteries, service contracts, hearing aid repairs, and all charges after the Plan has paid $500 for a hearing aid*	*All charges*	*All charges*
Durable medical equipment (DME)	**Standard Option**	**Value Plan**
Durable medical equipment (DME) is equipment and supplies that: 1. are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. are medically necessary; 3. are primarily and customarily used only for a medical purpose; 4. are generally useful only to a person with an illness or injury; 5. are designed for prolonged use; and 6. serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment, such as: • Oxygen and oxygen equipment • Dialysis equipment • Wheelchairs • Hospital beds • Ostomy supplies (including supplies purchased at a pharmacy) • Audible prescription reading devices Note: Preauthorization is required for audible prescription reading devices. Call us at 1-800-410-7778. See *Other services* under *You need prior Plan approval for certain services*, Section 3.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	**Standard Option**	**Value Plan**
For items that are available for purchase we will limit our benefit for the rental of durable medical equipment to an amount no greater than what we would have paid if the equipment had been purchased. For coordination of benefits purposes, when we are the secondary payor, we will limit our allowance for rental charges to the amount we would have paid for the purchase of the equipment, except when the primary payor is Medicare Part B and Medicare elects to continue renting the item. Note: Call us at 1-800-410-7778 for details about coverage and information about durable medical equipment Network providers. Note: When Medicare Part B is your primary payor, diabetic supplies, such as glucose meters and testing materials are covered under this benefit, even if purchased at a pharmacy. Note: See *Treatment therapies*, Section 5(a), for coverage of hyperbaric oxygen therapy. Note: We will only cover the cost of standard equipment. Coverage for specialty items such as all terrain wheelchairs is limited to the cost of the standard equipment. Note: See *Maternity care*, page xxx, for coverage of breastfeeding equipment	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Augmentative and alternative communication (AAC) devices	All charges after the Plan has paid $500 per device (No deductible)	All charges after the Plan has paid $500 per device (No deductible)
Not covered: • *Equipment replacements provided less than 3 years after the last one we covered* • *Charges for service contracts for purchased or rented equipment, except for purchased oxygen concentrators* • *Safety, hygiene, convenience and exercise equipment; bedside commodes* • *Household or vehicle modifications including seat, chair or van lifts; car seats; computer switchboard* • *Air conditioners, air purifiers, humidifiers, ultraviolet lighting (except for the treatment of psoriasis), heating pads, hot/cold packs, sun or heat lamps* • *Wigs or hair pieces*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Durable medical equipment (DME) (cont.)	**Standard Option**	**Value Plan**
• *Motorized scooters (see Definitions, Section 10), ramps, prone standers and other items that do not meet the DME definition* • *Dental appliances used to treat sleep apnea and/or temporomandibular joint dysfunction* • *Charges for educational/instructional advice on how to use the durable medical equipment* • *All rental charges above the purchase price or charges in excess of the secondary payor amount when we are the secondary payor, except as noted under covered Durable medical equipment* • *Customization or personalization of equipment* • *Blood pressure monitors* • *Enuresis alarms* • *All charges for AAC devices after the Plan has paid $500 per device*	*All charges*	*All charges*
Home health services - nursing services	**Standard Option**	**Value Plan**
A registered nurse (R.N.) or licensed practical nurse (L.P.N.) is covered for outpatient services when: • prescribed by your attending physician (i.e., the physician who is treating your illness or injury) for outpatient services; • the physician indicates the length of time the services are needed; and • the physician identifies the specific professional skills required by the patient and the medical necessity for skilled services. Note: Benefits are limited to 6 visits (Standard Option) or 4 visits (Value Plan) per person per calendar year. Note: Services of a Christian Science Nurse are covered under this benefit.	Network: 10% of the Plan's allowance and all charges after 6 visits Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after 6 visits	Network: 20% of the Plan's allowance and all charges after 4 visits Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after 4 visits
Not covered: • *Inpatient private duty nursing* • *Nursing care requested by, or for the convenience of, the patient or the patient's family;*	*All charges*	*All charges*

Home health services - nursing services - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Home health services - nursing services (cont.)	**Standard Option**	**Value Plan**
• *Services and supplies primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication* • *All charges after 6 visits (Standard Option) or 4 visits (Value Plan) per person per calendar year*	*All charges*	*All charges*
Chiropractic	**Standard Option**	**Value Plan**
Chiropractic care • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation and vibratory therapy Note: The 26-visit per person combined therapies annual maximum includes all covered services and supplies billed for these therapies. When more than one type of therapy, for example chiropractic and acupuncture, are provided on the same day, each will be counted as a separate visit.	Network: $20 copayment per visit and all charges after the Plan has paid the 26-visit combined therapies maximum (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid the 26-visit combined therapies maximum (No deductible).	Network: 20% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined rehabilitative, chiropractic and alternative treatment therapies maximum Non-Network: All charges
Alternative treatments	**Standard Option**	**Value Plan**
Acupuncture Note: The 26-visit per person combined therapies annual maximum includes all covered services and supplies billed for these therapies. When more than one type of therapy, for example chiropractic and acupuncture, are provided on the same day, each will be counted as a separate visit.	Network: 10% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined therapies maximum. Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid the 26-visit combined therapies maximum.	Network: 20% of the Plan's allowance and all charges after the Plan has paid the 26-visit combined therapies maximum. Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges after the Plan has paid the 26-visit combined therapies maximum.
Not covered: • *Naturopathic and homeopathic services* • *Chelation therapy and related services, except as part of a preauthorized treatment plan that we have approved* • *Thermography, biofeedback and related visits* • *Massagetherapy, acupressure, hypnotherapy* • *Self care or home management training or programs* • *All charges after the Plan has paid the 26-visit per person combined therapies annual maximum*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible...	
Educational classes and programs	**Standard Option**	**Value Plan**
Tobacco cessation • QuitPower® tobacco cessation program covers up to two quit attempts per member per calendar year, including up to five counseling sessions per quit attempt. Members may enroll in the QuitPower® program by calling 1-877-784-8797.	Nothing (No deductible)	Nothing (No deductible)
• Physician-prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence may be obtained from a retail pharmacy or through our mail order drug program.	Network: Nothing (No deductible) Non-Network: Any difference between the Plan's allowance and the billed amount (No deductible)	Network: Nothing (No deductible) Non-Network: All charges
Individual diabetic education provided by a health care professional for members with an established diagnosis of diabetes, including: • Educational supplies • Patient instruction • Medical nutrition therapy Note: Please contact us at 1-800-410-7778 to obtain information on the specific services covered under this benefit. Note: We offer a diabetes management incentive program that will reward participating members who comply with the program's requirements. See *Special features*, Section 5(h).	Network: 10% of the Plan's allowance Non-Network: All charges	Network: 20% of the Plan's allowance Non-Network: All charges
Weight management Outpatient, non-surgical treatment for members age 18 and over with body mass index (BMI) over 30, limited to the following covered services: • Initial evaluation by your physician • Follow-up visits to your physician • Individual or group behavioral counseling • Initial and follow-up lab tests Note: Please contact us at 1-800-410-7778 to obtain information on the specific services covered under this benefit. Note: Related prescription and over-the-counter (OTC) drugs are not covered under this benefit, but may be available through our discount drug program. See *Discount drug program*, Section 5(h).	All charges after the Plan has paid $1,000 per person per calendar year (No deductible)	All charges after the Plan has paid $1,000 per person per calendar year (No deductible)
Not covered:	*All charges*	*All charges*

Educational classes and programs - continued on next page

Benefit Description	You pay After the calendar year deductible...	
Educational classes and programs (cont.)	**Standard Option**	**Value Plan**
• *Self help or self management programs such as diabetic self management, except diabetic education described above* • *Charges for educational/instructional advice on how to use durable medical equipment* • *Programs for nocturnal enuresis* • *Diabetic education classes or sessions provided in a group setting* • *Exercise or weight loss programs and exercise equipment, except as described under Weight management, above* • *Nutritional supplements or food* • *All charges after the Plan has paid $1,000 for weight management services*	*All charges*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $400 per person ($800 per family) for services of Network providers and $600 per person ($1,500 per family) for services of Non-Network providers.
  - The Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of Network providers and $900 per person ($1,800 per family) for services of Non-Network providers.
- The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. When no Network provider is available, Non-Network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **PLEASE REMEMBER THAT ANY SURGICAL SERVICES THAT REQUIRE AN INPATIENT ADMISSION MUST BE PRECERTIFIED**. Please refer to the precertification information shown in Section 3.

Benefit Description	You Pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Surgical procedures	**Standard Option**	**Value Plan**
A comprehensive range of services, such as: • Operative procedures (performed by the primary surgeon) • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures (diagnostic and surgical) • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices. (See Section 5(a) – *Orthopedic and prosthetic devices* for device coverage information) • Voluntary sterilization for men • Treatment of severe burns • Correction of amblyopia & strabismus	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (no deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Surgical procedures (cont.)	**Standard Option**	**Value Plan**
Note: Preauthorization is required for all spinal surgeries. Call us at 1-800-410-7778. See *Other services* under *You need prior Plan approval for certain services*, Section 3. Note: Voluntary sterilization procedures for women, and surgically implanted contraceptives and intrauterine devices (IUDs) are covered under *Family planning*, Section 5 (a).	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (no deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Surgical treatment of morbid obesity (bariatric surgery) – a diagnosed condition in which the body mass index is 40 or greater, or 35 or greater with co-morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction – when: • Morbid obesity has persisted for at least 3 years • There is no treatable metabolic cause for the obesity • Member has participated in a 3-month physician-supervised weight loss program that included dietary therapy, physical activity and behavior therapy within the past 6 months and has failed to lose weight • A psychological evaluation has been completed and member has been recommended for bariatric surgery • Member is age 18 or older Call us at 1-800-410-7778 for additional information about surgical treatment of morbid obesity. Note: Coverage is limited to one surgical treatment for morbid obesity per member per lifetime. Note: Preauthorization for surgical treatment of morbid obesity is required. Call us at 1-800-410-7778. See *Other services* under *You need prior Plan approval for certain services*, Section 3.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-Network: 40% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Surgical procedures (cont.)	**Standard Option**	**Value Plan**
Pain management Treatment and management of chronic musculoskeleteal pain through interventional procedures such as nerve blocks. Note: Preauthorization is required for pain management services. Call us at 1-800-410-7778 prior to scheduling treatment. See *Other services* under *You need prior Plan approval for certain services,* Section 3. Note: Benefits for these services will be paid at the Non-Network level when you receive services from a Non-Network provider.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures are performed during the same operative session by the same surgeon, the Plan's benefit is determined as follows: • For the primary procedure: - Network: the Plan's full allowance, or - Non-Network: the Plan's full allowance • For the secondary procedure and any other subsequent procedures: - Network: one-half of the Plan's allowance, unless the Network contract provides for a different amount, or - Non-Network: one-half of the Plan's allowance	Network: 10% of the Plan's allowance for the individual procedure Non-Network: 30% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount	Network: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for the individual procedure for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-Network: 40% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount
Co-surgeons When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 62.5% of what it would pay a single surgeon for the same procedure(s), unless the Network contract provides for a different amount.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-Network: 40% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount
Assistant surgeons	Network: Nothing (calendar year deductible applies) Non-Network: Any difference between our allowance and the billed amount	Network: Nothing (no deductible) Non-Network: Any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Surgical procedures (cont.)	**Standard Option**	**Value Plan**
Assistant surgical services when medically necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan's allowance for the assistant surgeon is 16% of the allowance for the surgery, unless the Network contract provides for a different amount.	Network: Nothing (calendar year deductible applies) Non-Network: Any difference between our allowance and the billed amount	Network: Nothing (no deductible) Non-Network: Any difference between our allowance and the billed amount
Not covered: • *Multiple or bilateral surgical procedures performed through the same incision that are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.* • *Reversal of voluntary sterilization* • *Services of a standby surgeon* • *Routine treatment of conditions of the foot except for services rendered to established diabetics* • *Cosmetic surgery (See definition under Reconstructive surgery, Not covered)* • *Radial keratotomy, laser and other refractive surgery* • *Pain management services that have not been preauthorized*	*All charges*	*All charges*
Reconstructive surgery	**Standard Option**	**Value Plan**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produces a major effect on the member's appearance, and - the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a congenital anomaly (a condition that existed at or from birth and is a significant deviation from the common form or norm). Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedemas	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-Network: 40% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Reconstructive surgery (cont.)	**Standard Option**	**Value Plan**
(See Section 5(a) *Orthopedic and prosthetic devices* for coverage of breast prostheses and surgical bras and replacements.) Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital for up to 48 hours after your admission.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-Network: 40% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury or caused by illness* • *Surgery related to sex transformations or sexual dysfunction* • *Charges for photographs to document physical conditions*	*All charges*	*All charges*
Oral and maxillofacial surgery	**Standard Option**	**Value Plan**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of impacted teeth that are not completely erupted (bony, partial bony, and soft tissue impactions) • Removal of stones from salivary ducts • Excision of leukoplakia, tori or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Temporomandibular joint dysfunction surgery • Other surgical procedures that do not involve the teeth or their supporting structures Note: The related hospitalization (inpatient and outpatient) is covered if medically necessary. See Section 5(c).	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing for services provided in the outpatient department of a hospital or an ambulatory surgical center (No deductible); 20% of the Plan's allowance for services provided during an inpatient hospitalization or in a physician's office (calendar year deductible applies) Non-Network: 40% of the Plan's allowance for the individual procedure and any difference between our allowance and the billed amount

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible…	
Oral and maxillofacial surgery (cont.)	**Standard Option**	**Value Plan**
Not covered: • *Oral/dental implants and transplants* • *Procedures that involve the teeth or their supporting structures, such as the periodontal membrane, gingiva, and alveolar bone* • *Conservative treatment of temporomandibular joint dysfunction (TMJ)* • *Dental/oral surgical splints and stents* • *Orthodontic treatment*	*All charges*	*All charges*

Prior Authorization

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

Aetna Transplant Network

The Plan participates in the Aetna Institutes of Excellence Transplant Network program. Because transplantation is a highly specialized area, not all Network hospitals are part of the Aetna Institutes of Excellence program.

- **To qualify for this program, you, your representative, the doctor, or the hospital must call us at 1-800-410-7778 as soon as the possibility of a transplant is discussed.** When you call, you will be given information about the program and participating facilities.
- To receive the Aetna Transplant Network level of benefits, you must choose an Aetna Institutes of Excellence facility, and all transplant-related services must be received at that facility.
- All transplant admissions must be precertified.
- To use the Aetna Institutes of Excellence program, this must be your primary plan for payment of benefits.

Travel Benefit – for patients using the Aetna Institutes of Excellence program, the Plan may approve reasonable travel, lodging and meal expenses (if the recipient lives more than 50 miles one-way from the facility) up to $10,000 per transplant for the recipient and one companion (two companions if the recipient is a minor) and your organ donor, if applicable. For more information, contact us at 1-800-410-7778 before scheduling your pre-transplant evaluation.

Donor Coverage

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

Benefit Limitations

The maximum benefit for any organ/tissue transplant(s) is:

- Aetna Transplant Network: $1,000,000 per occurrence, which includes the following transplant-related expenses: pre-transplant evaluation, inpatient and outpatient hospital care, postoperative follow-up care, physician services and donor expenses as described above. To use the Aetna Transplant Network, this must be your primary plan for payment of benefits. Benefits begin on the first date of evaluation for transplant and end one year after the date of transplant for solid organ transplants, or 6 months after the date of stem cell infusion for blood or marrow stem cell transplants.
- Network and Non-Network: $200,000 per occurrence for Network services or $100,000 per occurrence for Non-Network services. These benefit maximums include:
  - Solid organ transplants: all transplant-related expenses from the date of the transplant procedure until the date of discharge from the hospital following the procedure.
  - Autologous blood or marrow stem cell transplants: all inpatient and outpatient transplant-related services from the date of mobilization of stem cells to three months after the date of cell infusion.
  - Allogeneic blood or marrow stem cell transplants: all inpatient and outpatient transplant-related services from the date of pre-transplant high-dose ablation chemotherapy to three months after the date of cell infusion.

Expenses related to complications arising during the transplant admission are considered part of the same occurrence. Outpatient prescription drugs and approved travel expenses related to the transplant are not subject to the transplant maximums. See Section 5(c) for coverage of transplant-related services provided by a hospital.

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

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

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

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants	**Standard Option**	**Value Plan**
Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Liver/Kidney • Pancreas* • Kidney/Pancreas • Lung: single, bilateral, lobar • Intestinal transplants - isolated small intestine - small intestine with the liver - small intestine with multiple organs such as the liver, stomach, and pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000. Network: 15% of the Plan's allowance; all charges over $200,000. Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000.	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000. Network: 20% of the Plan's allowance; all charges over $200,000. Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000.

Organ/tissue transplants - continued on next page

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Standard Option**	**Value Plan**
Note: Corneal transplants are not part of the Aetna Institutes of Excellence program. Benefits will be paid as described under *Surgical procedures*, Section 5(b). *Note: Pancreas (only) transplants are covered for insulin dependent (or Type 1) diabetes mellitus when exogenous treatment with insulin is deemed ineffective by the Plan.	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000. Network: 15% of the Plan's allowance; all charges over $200,000. Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000.	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000. Network: 20% of the Plan's allowance; all charges over $200,000. Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000.
Blood or marrow stem cell transplants, limited to the indicated stages of the following diagnoses (the medical necessity limitation is considered satisfied if the patient meets the staging description): • Allogeneic (donor) transplants for: - acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - acute myeloid leukemia - chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - severe or very severe aplastic anemia - severe combined immuno-deficiency disease - phagocytic/hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - advanced Hodgkin's lymphoma - relapsed - advanced non-Hodgkin's lymphoma - relapsed - hemoglobinopathy - marrow failure and related disorders (i.e., Fanconi's PNH, pure red cell aplasia) - myelodysplasia/myelodysplastic syndromes - amyloidosis - paroxysmal nocturnal hemoglobinuria - infantile malignant osteopetrosis - advanced neuroblastoma - Kostmann's syndrome - leukocyte adhesion deficiencies - mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000 Network: 15% of the Plan's allowance; all charges over $200,000 Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000 Network: 20% of the Plan's allowance; all charges over $200,000 Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000

Organ/tissue transplants - continued on next page

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Standard Option**	**Value Plan**
- mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - myeloproliferative disorders (MPDs) - advanced myeloproliferative disorders (MPDs) - sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous (self) bone marrow transplants (autologous stem cell and peripheral stem cell support) for: - acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - advanced Hodgkin's lymphoma - relapsed - advanced non-Hodgkin's lymphoma - relapsed - neuroblastoma - testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - multiple myeloma - de novo myeloma - amyloidosis - medulloblastoma • Autologous tandem bone marrow transplants for: - AL amyloidosis - multiple myeloma (de novo and treated) - recurrent testicular and other germ cell tumors	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000 Network: 15% of the Plan's allowance; all charges over $200,000 Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000 Network: 20% of the Plan's allowance; all charges over $200,000 Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000
Blood or marrow stem cell transplants in randomized and controlled Phase III clinical trials that are sponsored by the National Cancer Institute (NCI) or the National Institutes of Health (NIH), limited to: • Allogeneic (donor) transplants for: - early stage (indolent or non-advanced) small cell lymphocytic lymphoma - multiple myeloma - multiple sclerosis - chronic inflammatory demyelinating polyneuropathy (CIPD) • Nonmyeloablative allogeneic transplants or Reduced intensity conditioning (RIC)for:	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000 Network: 15% of the Plan's allowance; all charges over $200,000 Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000 Network: 20% of the Plan's allowance; all charges over $200,000 Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000

Organ/tissue transplants - continued on next page

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Standard Option**	**Value Plan**
- acute lymphocytic or non-lymphocytic (i. e., myelogenous) leukemia - advanced Hodgkins lymphoma - advanced non-Hodgkins lymphoma - breast cancer - chronic lymphocytic leukemia /small lymphocytic lymphoma (CLL/SLL) - chronic myelogenous leukemia - colon cancer - early stage (indolent or non-advanced) small cell lymphocytic lymphoma - multiple myeloma - multiple sclerosis - myeloproliferative disorders - myelodysplasia/myelodysplastic syndromes - non-small cell lung cancer - ovarian cancer - prostate cancer - renal cell carcinoma - sarcomas - sickle cell disease • Autologous transplants for: - chronic myelogenous leukemia - chronic lymphocytic leukemia /small lymphocytic lymphoma (CLL/SLL) - early stage (indolent or non-advanced) small cell lymphocytic lymphoma - small cell lung cancer - breast cancer - epithelial ovarian cancer - multiple sclerosis - systemic lupus erythematosis - systemic sclerosis - scleroderma - scleroderma SSc (severe, progressive) - childhood rhabdomyosarcoma - advanced Ewing sarcoma - advanced childhood kidney cancers - mantle cell (non-Hodgkins lymphoma)	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000 Network: 15% of the Plan's allowance; all charges over $200,000 Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000	Aetna Transplant Network: 10% of the Plan's allowance; all charges over $1,000,000 Network: 20% of the Plan's allowance; all charges over $200,000 Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount; all charges over $100,000
Not covered:	*All charges*	*All charges*

Organ/tissue transplants - continued on next page

Benefit description	You pay After the calendar year deductible...	
Organ/tissue transplants (cont.)	**Standard Option**	**Value Plan**
• *Expenses for services or supplies specifically excluded by the Plan, unless part of a treatment plan approved throughthe Aetna Transplant Network* • *Donor screening and search expenses after four screened donors, except when approved through the Aetna Transplant Network* • *Travel, lodging and meal expenses not approved by the Plan* • *Services and supplies for or related to transplants not listed as covered. Related services or supplies include administration of chemotherapy when supported by transplant procedures.*	*All charges*	*All charges*
Anesthesia	**Standard Option**	**Value Plan**
Professional services for the administration of anesthesia in hospital and out of hospital Note: When multiple anesthesia providers are involved during the same surgical session, the Plan's allowance for each anesthesia provider will be determined using CMS guidelines.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount If you use a Network facility, we pay Network benefits when you receive services from an anesthesiologist who is not a Network provider. See *We have Network providers*, Section 1, for further details.	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount If you use a Network facility, we pay Network benefits when you receive services from an anesthesiologist who is not a Network provider. See *We have Network providers*, Section 1, for further details.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)". If applicable:
  - the Standard Option calendar year deductible is $400 per person ($800 per family) for services of Network providers and $600 per person ($1,500 per family) for services of Non-Network providers.
  - the Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of Network providers and $900 per person ($1,800 per family) for services of Non-Network providers.
- The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. When no Network provider is available, Non-Network benefits apply. To help keep your out-of-pocket costs for coinsurance to a minimum, we encourage you to contact us for direction to Network providers whenever possible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Section 5(a) or Section 5(b).
- Note: Observation care is billed as outpatient facility care. As a result, benefits for observation care services are provided at the outpatient facility benefit levels. See *Observation care*, Section 10, for more information about these types of services.
- Note: When you use a Network 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 Network providers.
- YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY. Please refer to the precertification information shown in Section 3.

Benefit Description	You pay	
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".		
Inpatient hospital	**Standard Option**	**Value Plan**
Room and board, such as • Ward, semiprivate, or intensive care accommodations, including birthing centers • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, our benefit will be based on the hospital's average charge for semiprivate accommodations.	Aetna Transplant Network: Nothing Network: Nothing Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance (calendar year deductible applies) Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**Standard Option**	**Value Plan**
Note: Hospitals billing an all-inclusive rate will be prorated between room and board and ancillary charges.	Aetna Transplant Network: Nothing Network: Nothing Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance (calendar year deductible applies) Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Other hospital services and supplies (ancillary services), such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic tests, such as X-rays, laboratory and pathology services, MRIs, and CAT Scans • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Autologous blood donations • Internal prosthesis Note: We base our payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its anesthetists' services, we pay Hospital benefits and when the anesthetist bills, we pay under Section 5(b). Note: The maximum benefit for any organ/tissue transplant(s) as described in Section 5(b) *Organ/tissue transplants* is: • Aetna Transplant Network: $1,000,000 per occurrence. To use the Aetna Institutes of Excellence program, this must be your primary plan for payment of benefits. • Network and Non-Network: $200,000 per occurrence for Network services or $100,000 per occurrence for Non-Network services.	Aetna Transplant Network: $200 copayment per admission and 10% of the Plan's allowance Network: $200 copayment per admission and 15% of the Plan's allowance Note: For inpatient hospital care related to maternity, including care at birthing facilities, we waive the per-admission copayment and the coinsurance and pay for covered services in full for care provided by a Network facility. Non-Network: $500 copayment per admission plus 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance (calendar year deductible applies) Network: 20% of the Plan's allowance (calendar year deductible applies) Note: For inpatient hospital care related to maternity, including care at birthing facilities, we waive the calendar year deductible and the coinsurance and pay for covered services in full for care provided by a Network facility. Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**Standard Option**	**Value Plan**
Expenses related to complications arising during the transplant admission are considered part of the same occurrence. Outpatient prescription drugs and approved travel expenses related to the transplant are not subject to the transplant maximums. See Section 5(b) for transplant-related professional services. Note: To use the Aetna Institutes of Excellence program, this must be your primary plan for payment of benefits. Note: Chemotherapy, when supported by a bone marrow transplant or autologous stem cell support is covered only for the specific diagnoses listed in Section 5(b) *Organ/tissue transplants*. Note: The Plan pays Inpatient Hospital Benefits as shown above in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. Note: Benefits for admission to Christian Science nursing facilities are limited to 50 days per person per calendar year.	Aetna Transplant Network: $200 copayment per admission and 10% of the Plan's allowance Network: $200 copayment per admission and 15% of the Plan's allowance Note: For inpatient hospital care related to maternity, including care at birthing facilities, we waive the per-admission copayment and the coinsurance and pay for covered services in full for care provided by a Network facility. Non-Network: $500 copayment per admission plus 30% of the Plan's allowance and any difference between our allowance and the billed amount	Aetna Transplant Network: 10% of the Plan's allowance (calendar year deductible applies) Network: 20% of the Plan's allowance (calendar year deductible applies) Note: For inpatient hospital care related to maternity, including care at birthing facilities, we waive the calendar year deductible and the coinsurance and pay for covered services in full for care provided by a Network facility. Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *A hospital admission, or portion thereof, that is not medically necessary (see definition), including an admission for medical services that did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered* • *Hospital admissions for medical rehabilitation unless the admission is to an approved acute inpatient rehabilitation facility and the patient can actively participate in a minimum of 3 hours of acute inpatient rehabilitation to include any combination of the following therapies: physical, occupational, speech, respiratory therapy per day* • *Custodial care; see Section 10 Definitions* • *Non-covered facilities, such as nursing homes, subacute care facilities, extended care facilities, schools, domiciliaries and rest homes*	*All charges*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**Standard Option**	**Value Plan**
• *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private inpatient nursing care* • *Institutions that do not meet the definition of covered hospitals* • *All charges after 50 days for services provided by a Christian Science nursing facility*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**Standard Option**	**Value Plan**
Services and supplies related to outpatient surgical procedures, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic tests, such as X-rays, laboratory and pathology services • CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT Note: Preauthorization for these procedures is required. Call us at 1-800-410-7778 prior to scheduling. See *Outpatient imaging procedures* under *You need prior Plan approval for certain services*, Section 3. • Blood and blood plasma, if not donated or replaced, and other biologicals, including administration • Dressings, casts, and sterile tray services • Medical supplies, including anesthesia and oxygen • Anesthetics and anesthesia services Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. Note: If the stay is greater than 23 hours and you are admitted, you need to precertify the admission. Note: For services billed by a surgeon or anesthetist, see Section 5(b). For services related to an accidental injury or medical emergency, see Section 5(d).	Network: 10% of the Plan's allowance (calendar year deductible applies) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: $200 copayment per occurrence (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Services and supplies related to outpatient maternity care, including care at birthing facilities, such as:	Network: Nothing (No deductible)	Network: Nothing (No deductible)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Value Plan**
• Delivery, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic tests, such as X-rays, ultrasound, laboratory and pathology services • CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT Note: Preauthorization for these procedures is required. Call us at 1-800-410-7778 prior to scheduling. See *Outpatient imaging procedures* under *You need prior Plan approval for certain services*, Section 3. • Medical supplies, including anesthesia and oxygen Note: For services billed by a surgeon or anesthetist, see Section 5(b).	Network: Nothing (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: Nothing (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Services and supplies related to outpatient diagnostic testing and rehabilitative therapy, such as: • Diagnostic tests, such as X-rays, laboratory and pathology services • CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT Note: Preauthorization for these procedures is required. Call us at 1-800-410-7778 prior to scheduling. See *Outpatient imaging procedures* under *You need prior Plan approval for certain services*, Section 3. • Physical, speech and occupational therapy Note: The 26-visit per person combined therapies annual maximum includes all covered services and supplies billed for these therapies. • Treatment rooms Note: If the stay is greater than 23 hours and you are admitted, you need to precertify the admission. Note: For services related to an accidental injury or medical emergency, see Section 5(d).	Network: 10% of the Plan's allowance (calendar year deductible applies) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Services and supplies for outpatient diagnostic and treatment services not related to surgical procedures, such as: • Treatment and observation rooms	Network: 10% of the Plan's allowance (calendar year deductible applies)	Network: 20% of the Plan's allowance (calendar year deductible applies)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay	
Outpatient hospital or ambulatory surgical center (cont.)	**Standard Option**	**Value Plan**
• Non-emergency treatment provided in an emergency room • Chemotherapy and radiation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy • Hyperbaric oxygen therapy • Respiratory and inhalation therapy • Growth hormone therapy Note: Pharmacy charges for growth hormones, are covered under *Prescription drug benefits*, Section 5(f), and require preauthorization. See *Specialty drugs*, Section 5(f), and *Other services* under *You need prior Plan approval for certain services*, Section 3. • Medical supplies, including oxygen Note: If the stay is greater than 23 hours and you are admitted, you need to precertify the admission. Note: Observation care is covered up to a maximum of 48 hours, unless the applicable Network agreement provides otherwise. For observation care in excess of 48 hours, we will review for appropriateness of care to determine benefits. See *Observation care* , Section 10. Note: For services related to an accidental injury or medical emergency, see Section 5(d).	Network: 10% of the Plan's allowance (calendar year deductible applies) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Surgical facility charges billed by entities that are not accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF), or the Accreditation Association for Ambulatory Health Care (AAAHC), or which do not have Medicare certification as an ASC facility.* • *Expenses for observation/status rooms and related services in excess of 48 hours that does not meet our criteria for coverage.*	*All charges*	*All charges*

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits	**Standard Option**	**Value Plan**
Semiprivate room, board, services and supplies provided in a skilled nursing care facility (SNF) for up to 15 days per calendar year when: • you are admitted directly from a covered inpatient hospital stay of at least 3 consecutive days; and • you are admitted to the SNF for the same condition as the hospital stay; and • your care is provided by an R.N., L.P.N., or L.V.N. and is directed and supervised by a doctor (M.D. or D.O.) Note: Preauthorization for these services is required. Call us at 1-800-410-7778. See *Other services* under *You need prior Plan approval for certain services*, Section 3. Note: Benefits are available only when this plan is the primary payor for health benefits. When another plan, including Medicare, is the primary payor, these benefits are not payable.	Network: 10% of the Plan's allowance for up to 15 days per person per calendar year; all charges after 15 days Non-Network: 30% of the Plan's allowance for up to 15 days per person per calendar year and any difference between our allowance and the billed amount; all charges after 15 days	Network: 20% of the Plan's allowance for up to 15 days per person per calendar year; all charges after 15 days (calendar year deductible applies) Non-Network: 40% of the Plan's allowance for up to 15 days per person per calendar year and any difference between our allowance and the billed amount; all charges after 15 days (calendar year deductible applies)
Not covered: • *Custodial care (see Section 10, Definitions)* • *All charges after 15 days per person per calendar year*	*All charges*	*All charges*
Hospice care	**Standard Option**	**Value Plan**
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. Any combination of inpatient and outpatient services up to 15 days per person per calendar year. If you use a Network provider, your out-of-pocket expenses will be reduced.	Network: Nothing, up to 15 days per person per calendar year; all charges after 15 days Non-Network: Any difference between our allowance and the billed amount; all charges after 15 days	Network: Nothing, up to 15 days per person per calendar year; all charges after 15 days Non-Network: Any difference between our allowance and the billed amount; all charges after 15 days
Not covered: • *Independent nursing, and homemaker services* • *All charges after 15 days per person per calendar year*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**Standard Option**	**Value Plan**
Local professional ambulance service when medically appropriate to the first hospital where treated and from that hospital to the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Services must be related to: • an accidental injury or medical emergency, • a covered inpatient hospitalization, • a direct transfer from a covered inpatient hospitalization to a covered skilled nursing facility confinement, or • covered hospice care. Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition requires immediate evacuation. Note: Benefits for air or ground ambulance transportation that is not to the nearest hospital where appropriate treatment is available will be prorated based on mileage to the nearest hospital where appropriate treatment is available.	Network: 10% of the Plan's allowance (calendar year deductible applies) Non-Network: 30% of thePlan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of thePlan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Transportation to other than a hospital, skilled nursing facility, hospice or urgent care medical facility* *Transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests, except as part of covered inpatient hospital care* • *Expenses for ambulance services when the patient is not actually transported*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- These benefits are payable instead of any other benefit under this Plan for emergency treatment of accidental injuries and medical emergencies.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $400 per person ($800 per family) for services of Network providers and $600 per person ($1,500 per family) for services of Non-Network providers.
  - The Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of Network providers and $900 per person ($1,800 per family) for services of Non-Network providers.
- The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. When no Network provider is available, Non-Network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.

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

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

Benefit Description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury	**Standard Option**	**Value Plan**
If you receive outpatient care for your accidental injury in a hospital emergency room, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery and related services Note: We pay Inpatient hospital benefits if you are admitted. See Section 5(c).	Network: $200 copayment per occurrence for the first five (5) emergency room visits per person per calendar year, $600 copayment per occurrence for all subsequent visits (No deductible) (if admitted to the hospital, copayment is waived)	Network: 20% of the Plan's allowance for the first five (5) emergency room visits per person per calendar year, 40% of the Plan's allowance for all subsequent visits Non-Network: 20% of thePlan's allowance and any difference between our allowance and the billed amount for the first five (5) emergency room visits per person per calendar year, 40% of the Plan's allowance and any difference between our allowance and the billed amount for all subsequent visits

Accidental injury - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Accidental injury (cont.)	**Standard Option**	**Value Plan**
Note: Observation care is covered up to a maximum of 48 hours, unless the applicable Network agreement provides otherwise. For observation care in excess of 48 hours, we will review for appropriateness of care to determine benefits. See *Outpatient hospital or ambulatory surgical center*, Section 5(c), and *Observation care* , Section 10, for more information. Note: Repair of sound natural teeth due to an accidental injury is covered under this benefit. The services and supplies must be provided within one year of the accident and the patient must be a member of the Plan at the time services were rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	Network: $200 copayment per occurrence for the first five (5) emergency room visits per person per calendar year, $600 copayment per occurrence for all subsequent visits (No deductible) (if admitted to the hospital, copayment is waived) Non-Network: $200 copayment per occurrence and any difference between our allowance and the billed amount for the first five (5) emergency room visits per person per calendar year, $600 copayment per occurrence and any difference between our allowance and the billed amount for all subsequent visits (No deductible) (if admitted to the hospital, copayment is waived)	Network: 20% of the Plan's allowance for the first five (5) emergency room visits per person per calendar year, 40% of the Plan's allowance for all subsequent visits Non-Network: 20% of thePlan's allowance and any difference between our allowance and the billed amount for the first five (5) emergency room visits per person per calendar year, 40% of the Plan's allowance and any difference between our allowance and the billed amount for all subsequent visits
If you receive outpatient care for your accidental injury in an urgent care center, we cover: • Non-surgical physician services and supplies • Surgery and related services Note: Repair of sound natural teeth due to an accidental injury is covered under this benefit. The services and supplies must be provided within one year of the accident and the patient must be a member of the Plan at the time services were rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	Network: $50 copayment per occurrence (No deductible) Non-Network: 30% of thePlan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: 20% of the Plan's allowance (no deductible) Non-Network: 40% of thePlan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Non-surgical physician services provided in a doctor's office for your accidental injury Note: Repair of sound natural teeth due to an accidental injury is covered under this benefit. The services and supplies must be provided within one year of the accident and the patient must be a member of the Plan at the time services were rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	Network: $20 copayment per office visit for adults (No deductible), $10 copayment per office visit for dependent children through age 21 (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies)	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Accidental injury - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Accidental injury (cont.)	**Standard Option**	**Value Plan**
	Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)	
Medical emergency	**Standard Option**	**Value Plan**
If you receive outpatient care for your medical emergency in a hospital emergency room, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services • Observation room • Surgery and related services Note: We pay Inpatient hospital benefits if you are admitted. See Section 5(c). Note: Observation care is covered up to a maximum of 48 hours, unless the applicable Network agreement provides otherwise. For observation care in excess of 48 hours, we will review for appropriateness of care to determine benefits. See *Outpatient hospital or ambulatory surgical center*, Section 5(c), and *Observation care* , Section 10, for more information.	Network: $200 copayment per occurrence for the first five (5) emergency room visits per person per calendar year, $600 copayment per occurrence for all subsequent visits (if admitted to the hospital, copayment is waived) Non-Network: $200 copayment per occurrence and any difference between our allowance and the billed amount for the first five (5) emergency room visits per person per calendar year, $600 copayment per occurrence and any difference between our allowance and the billed amount for all subsequent visits (if admitted to the hospital, copayment is waived)	Network: 20% of the Plan's allowance for the first five (5) emergency room visits per person per calendar year, 40% of the Plan's allowance for all subsequent visits Non-Network: 20% of the Plan's allowance and any difference between our allowance and the billed amount for the first five (5) emergency room visits per person per calendar year, 40% of the Plan's allowance and any difference between our allowance and the billed amount for all subsequent visits
If you receive outpatient care for your medical emergency in an urgent care center, we cover: • Non-surgical physician services and supplies • Surgery and related services	Network: $50 copayment per occurrence Non-Network: 30% of thePlan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of thePlan's allowance and any difference between our allowance and the billed amount
Non-surgical physician services provided in a doctor's office for your medical emergency.	PPO: $20 copayment per office visit for adults (No deductible), $10 copayment per office visit for dependent children through age 21 (No deductible); and 10% of the Plan's allowance for other services performed during the visit (calendar year deductible applies)	PPO: 20% of the Plan's allowance Non-PPO: 40% of the Plan's allowance and any difference between our allowance and the billed amount

Medical emergency - continued on next page

Benefit Description	You pay After the calendar year deductible…	
Medical emergency (cont.)	**Standard Option**	**Value Plan**
	Non-PPO: 30% of the Plan's allowance and any difference between our allowance and the billed amount per office visit (No deductible); 30% of the Plan's allowance and any difference between our allowance and the billed amount for other services (calendar year deductible applies)	
Ambulance	**Standard Option**	**Value Plan**
Local professional ambulance service when medically appropriate to the first hospital where treated and from that hospital to the next nearest hospital or medical facility if necessary treatment is not available at the first hospital. Services must be related to: • an accidental injury or medical emergency, • a covered inpatient hospitalization, • a direct transfer from a covered inpatient hospitalization to a covered skilled nursing facility confinement, or • covered hospice care. Air ambulance to the nearest hospital where treatment is available and only if there is no emergency ground transportation available or suitable and the patient's condition warrants immediate evacuation. Note: Benefits for air or ground ambulance transportation that is not to the nearest hospital where appropriate treatment is available will be prorated based on mileage to the nearest hospital where appropriate treatment is available.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Not covered: • *Transportation to other than a hospital, skilled nursing facility, hospice or urgent care medical facility* • *Ambulance and any other modes of transportation to or from services including but not limited to physician appointments, dialysis, or diagnostic tests, except as part of covered inpatient hospital care* • *Expenses for ambulance services when the patient is not actually transported*	*All charges*	*All charges*

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary and/or clinically appropriate.
- These benefits are payable instead of any other benefits under this Plan for services related to treatment of mental health and substance abuse.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $400 per person ($800 per family) for services of Network providers and $600 per person ($1,500 per family) for services of Non-Network providers.
  - The Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of Network providers and $900 per person ($1,800 per family) for services of Non-Network providers.
- The Non-Network benefits are the regular benefits of this Plan. Network benefits apply only when you use a Network provider. When a Network provider is not available, Non-Network benefits apply.
- Network providers for mental health and substance abuse services are different from the Network providers available for medical services (see *Network providers for mental health and substance abuse*, Section 3). Call us at 1-800-410-7778 for assistance with locating a Network provider.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.
- YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY. Please refer to the precertification information shown in Section 3.

Benefits description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Professional services	**Standard Option**	**Value Plan**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, and marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnostic and treatment services: • Outpatient professional services, including individual or group therapy	Network: $20 copayment per office visit for adults (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)	Network: $30 copayment per visit (No deductible); $10 copayment per office visit for dependent children through age 21 (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)

Professional services - continued on next page

Benefits description	You pay After the calendar year deductible…	
Professional services (cont.)	**Standard Option**	**Value Plan**
• Inpatient professional services	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Diagnostics	**Standard Option**	**Value Plan**
Outpatient lab, X-ray and other diagnostic tests, including psychological and neuropsychological testing Note: Preauthorization for psychological and neuropsychological testing is required. Call us at 1-800-410-7778 prior to scheduling. See *Other services* under *You need prior Plan approval for certain services,* Section 3.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: Nothing (No deductible) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Inpatient hospital	**Standard Option**	**Value Plan**
Inpatient hospital: • Services provided by a hospital or other inpatient facility • Services in approved alternative care settings such as half-way house, residential treatment, full-day hospitalization Note: Preauthorization for these services is required. Call us at 1-800-410-7778 prior to scheduling. See *Other services* under *You need prior Plan approval for certain services,* Section 3.	Network: $200 copayment per admission, nothing for room and board and 15% of the Plan's allowance for hospital ancillary services (No deductible) Non-Network: $500 copayment per admission plus 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	Network: 20% of the Plan's allowance (calendar year deductible applies) Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Outpatient hospital	**Standard Option**	**Value Plan**
• Electroshock/electroconvulsive therapy • Partial hospitalization • Facility-based intensive outpatient treatment Note: Preauthorization for these services is required. Call us at 1-800-410-7778 prior to scheduling. See *Other services* under *You need prior Plan approval for certain services,* Section 3.	Network: 10% of the Plan's allowance Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount

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

Benefits description	You pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Not covered	**Standard Option**	**Value Plan**
• *Services that, in the Plan's judgment, are not medically necessary* • *Treatment of learning disorder or specific delays in development, treatment of mental retardation or intellectual disability* • *Treatment for binge eating disorder and gambling disorder* • *Services rendered or billed by schools* • *Services provided by Non-Network residential treatment centers or halfway houses or members of their staffs, unless preauthorized* • *Applied behavioral analysis (ABA) therapy*	*All charges*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page xxx.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- There is no calendar year deductible for prescription drugs.
- YOU MUST GET PREAUTHORIZATION FOR CERTAIN DRUGS including, but not limited to, preferred and non-preferred brand name drugs when a generic equivalent is available, oncology drugs and Specialty drugs. For more information about preauthorization, please call us at 1-800-410-7778 or visit our website at www.MHBP.com.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.

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

- **Who can write your prescription?** A licensed physician or dentist, and in the states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, or by mail for certain drugs. We pay a higher level of benefits when you use a network pharmacy.
  - **Network pharmacy** – Present your Plan identification card at a network pharmacy to purchase prescription drugs. You must have the pharmacy file the claim electronically for you in order to receive the network pharmacy level benefit. Call 1-800-410-7778 or check the electronic directory via www.MHBP.com to locate the nearest network pharmacy.
  - **Non-Network pharmacy** – Standard Option members may purchase prescriptions at pharmacies that are not part of our network. You pay the full cost and must file a claim for reimbursement. See Section 7, *Filing a claim for covered services*. Benefits are not available under Value Plan for prescription drugs obtained from a non-network pharmacy.
  - **Mail order** – To obtain more information about the mail order drug program, order refills, check order status and request additional mail service envelopes and claim forms, or to ask questions about eligibility, copayments or other issues, call CVS Caremark at 1-866-623-1441 or visit our website, www.MHBP.com.
- **We use a formulary**. A formulary is a list of generic and preferred drugs (see below) that are available through this plan. It places all FDA approved drugs into categories based on their clinical effectiveness, safety and cost and is designed to control costs for you and the Plan. The categories include:
  - **Generic** drug category includes primarily generic drugs;
  - **Preferred** drug category (also called "formulary") includes preferred brand name drugs;
  - **Non-Preferred** drug category (also called "non-formulary") includes non-preferred brand name drugs;
  - **Specialty** drug category (see description of Specialty drugs below).

Occasionally, drugs may change from one category to another category, which can affect your cost-share amount. We will attempt to notify you when this occurs.

When you need a prescription, share the formulary with your physician and request a Generic or Preferred category drug if possible. By choosing Generic or Preferred category drugs, you may decrease your out-of-pocket expenses. While all FDA-approved drugs are available to you, we may have formulary restrictions on certain drugs, including but not limited to, quantity limits, age limits, dosage limits, brand exception and preauthorization. To request a copy of our current formulary, call us at 1-800-410-7778 or visit our website, www.MHBP.com.

- **A generic equivalent will be dispensed if it is available** when you obtain your prescription from a network pharmacy or through our mail order drug program. If you choose a brand name medication for which a generic medication exists, you will pay your cost-share plus the difference in cost between the brand name and generic medication. If you have a medical condition that requires a brand name drug your prescribing physician must obtain a brand exception. For information on how to obtain a brand exception, you or your physician should call us at 1-800-410-7778 or visit our website, www.MHBP.com. If the exception is not approved, your cost-sharing will be greater.
- **Why use generic drugs?** A generic drug is the chemical equivalent to a brand name drug, yet it costs much less. Choosing generic drugs rather than brand name drugs can reduce your out-of-pocket expenses. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. They must contain the same active ingredients, be equivalent in strength and dosage, and meet the same standards for safety, purity and effectiveness as the original brand name product.
- **Generic drug incentive program**. You may be eligible for this program if you are currently taking a non-generic medication and switch to a generic replacement for that drug. If you qualify, you will receive a letter from CVS Caremark indicating that you can receive up to a 90-day supply of the generic drug at no cost to you. You must obtain the generic replacement by the expiration date in the letter at a network retail pharmacy (up to three 30-day refills), or through our mail order drug program (one 90-day refill).
- **Maintenance and long-term medications.** A long-term maintenance medication is one that is taken regularly for chronic conditions or long-term therapy. A few examples include medications for managing high blood pressure, asthma, diabetes or high cholesterol. We have a program that allows members to get up to 90-day refills at a CVS retail pharmacy for the same cost-sharing as mail order. Under the program, you may choose to get the initial prescription and two refills (up to a 30-day supply each) at a network retail pharmacy or through our mail order drug program (up to a 90-day supply). After the second refill at a retail pharmacy, additional refills must be obtained either from a CVS retail pharmacy or through our mail order drug program. You will receive a letter after your second refill that describes your benefits and provides instructions on how to obtain additional refills in up to a 90-day supply. This program is required for Value Plan members.

  Standard Option members may choose **not** to participate in this program by calling CVS Caremark at 1-866-623-1441. If you exceed three fills at a network retail pharmacy and have not advised us that you do not want to participate in this program, you may experience a delay in receiving your medication until you contact us.
- **There are dispensing limitations.** All prescriptions will be limited to a 30-day supply for retail and a 90-day supply for mail order. Also, in most cases, refills cannot be obtained until 75% of the drug has been used. Occasionally, as part of regular review, we may recommend that the use of a drug is appropriate only with limits on its quantity, total dose, duration of therapy, age, gender or specific diagnoses. Since the prescription does not usually explain the reason your provider prescribed a medication, we may implement any of these limits and/or require preauthorization to confirm the intent of the prescriber.
- **Preauthorization**. We require preauthorization for certain drugs. To obtain a list of drugs that require preauthorization, please visit our website, www.MHBP.com or call 1-866-623-1441. We periodically review and update the preauthorization drug list in accordance with guidelines set by the US Food & Drug Administration (FDA), as a result of new drugs, new generic drugs, new therapies and other factors. Consult with your physician or pharmacist to determine if there are alternate drugs that do not require preauthorization and are appropriate for you. To request preauthorization, your physician may contact the CVS Caremark Preauthorization Department at 1-800-626-3046. CVS Caremark will work with your physician to obtain the information needed to evaluate the request. **You may contact CVS Caremark at 1-866 623-1441 for the status of your request and any questions you have regarding preauthorization**.
- **Specialty drugs**, including biotech drugs, require special handling and close monitoring, and are used to treat chronic complex conditions including, but not limited to: hemophilia, immune deficiency, growth hormone deficiencies, multiple sclerosis, Crohn's disease, hepatitis C, HIV, hormonal disorders, rheumatoid arthritis and pulmonary disorders.
  - **These drugs require preauthorization to determine medical necessity and appropriate utilization.**
  - **A specialty preferred drug trial must be completed before a non-preferred specialty drug will be authorized.**
  - **Specialty drugs, including specialty oral and self-administered drugs must be obtained from CVS Caremark Specialty Pharmacy.**
- We can accommodate your drug refill requests when you are called to active military duty or in the case of a declared emergency. Call 1-866-623-1441 in advance to request the accommodation.

- **The Plan conducts Drug Utilization Review (DUR).** When you fill your prescription at a network pharmacy or through the mail-order program, we and/or the pharmacist may electronically access information about prior prescriptions, checking for harmful drug interactions, drug duplication, excessive use and the frequency of refills. DUR helps protect against potentially dangerous drug interactions or inappropriate use. When appropriate, your pharmacist(s) and/or CVS Caremark may contact your physician(s) to discuss an alternative drug or treatment option, prescription drug compliance, and the best and most cost-effective use of services. In addition, we may perform a periodic review of prescriptions to help ensure your safety and to provide health education and support. Upon review, we may contact you or your provider(s) to discuss your current medical situation and may offer assistance in coordinating care and treatment. For more information about this program, call us at 1-866-623-1441.
- **When you have to file a claim.** Standard Option members who purchase prescriptions at a non-network pharmacy, mail your CVS Caremark claim form and prescription receipts to: CVS Caremark, Attn: Claims Department, P.O. Box 52196, Phoenix, AZ 85072-2196. Receipts must include the prescription number, name of drug, date, prescribing doctor's name, charge, name and address of drugstore and NDC number (included on the bill). See *How to claim benefits*, Section 7, for additional information.

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

Note: All drugs may not be available through the mail order program. Some of the drug classes that may not be available are: narcotics, hospital solutions and certain drugs such as antipsychotic agents and AIDS therapies and other drugs for which state or federal laws or medical judgment limit the dispensing amount to less than 90 days. In addition, some injectables may not be available through mail-order services. However, these excluded drugs are covered under the retail prescription drug program. For questions about the mail-order prescription drug program or to inquire about specific drugs or medications, please call 1-866-623-1441.

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

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

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

Benefits Description	You pay	
Note: The calendar year deductible does not apply to benefits in this section		
Covered medications and supplies	**Standard Option**	**Value Plan**
You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail (for certain prescription drugs): • Drugs and medicines that by Federal law of the United States require a doctor's written prescription, including chemotherapy and drugs used to treat the side effects of chemotherapy • Disposable needles and syringes, and alcohol swabs (if purchased at a pharmacy) • Insulin and related testing material • Oral contraceptives (brand name drugs that have a generic equivalent) Note: We cover generic oral contraceptive drugs and contraceptive devices as described under *Women's contraceptive drugs and devices*, below. For questions about the prescription drug program, or to obtain a copy of our current formulary, please call us at 1-800-410-7778 or visit our website at www.MHBP.com. Note: When you have a medical condition that requires a brand name drug for which a generic equivalent is available, your physician must obtain a brand exception for dispensing the brand name drug at a network retail pharmacy or through our mail order drug program. You or your physician should contact us at 1-800-410-7778 for instructions on how to obtain a brand exception. Note: When Medicare Part B is your primary coverage, we cover diabetic supplies, such as glucose meters and testing materials, under *Durable medical equipment*, Section 5(a). Note: When Medicare Parts A and B are your primary coverage, prescription drug benefits will be paid as described in this section.	Network pharmacy, up to a 30-day supply*: • Generic: $5 copayment per prescription • Preferred brand name (formulary) : 30% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained, limited to $200 per prescription • Non-Preferred brand name (non-formulary): 50% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained, limited to $200 per prescription Foreign pharmacy, up to a 90-day supply: • $10 copayment for each 30-day supply Non-network pharmacy and paper claims for prescriptions filled at a network pharmacy: • 50% of the Plan's allowance for the prescription and any difference between our allowance and the billed amount Mail order drug program, 31 to 90-day supply: • Generic: $10 copayment per prescription • Preferred brand name (formulary): $80 copayment per prescription and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained	Network pharmacy, up to a 30-day supply*: • Generic: $10 copayment per prescription • Preferred brand name (formulary): 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained • Non-Preferred brand name (non-formulary): 75% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained Foreign pharmacy, up to a 90-day supply: • $10 copayment for each 30-day supply Non-network pharmacy and paper claims for prescriptions filled at a network pharmacy: • All charges Mail order drug program, 31 to 90-day supply: • Generic: $30 copayment per prescription • Preferred brand name (formulary): 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained • Non-Preferred brand name (non-formulary): 75% of the Plan's allowance, and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained

Covered medications and supplies - continued on next page

Benefits Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Value Plan**
*Note: For long-term maintenance medications, we have a maintenance drug management program that allows members to get up to a 90-day supply at a CVS retail pharmacy for the same cost-sharing as mail order. Under the program, you may choose to get the initial prescription and two refills (up to a 30-day supply each) at a network retail pharmacy or up to a 90-day supply through our mail order drug program or a CVS retail pharmacy. After the second refill at a retail pharmacy, Value Plan members must obtain additional refills either from a CVS retail pharmacy or through our mail order drug program. Standard Option members may choose **not** to participate in this program by calling CVS Caremark at 1-866-623-1441.	Network pharmacy, up to a 30-day supply*: • Generic: $5 copayment per prescription • Preferred brand name (formulary) : 30% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained, limited to $200 per prescription • Non-Preferred brand name (non-formulary): 50% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained, limited to $200 per prescription Foreign pharmacy, up to a 90-day supply: • $10 copayment for each 30-day supply Non-network pharmacy and paper claims for prescriptions filled at a network pharmacy: • 50% of the Plan's allowance for the prescription and any difference between our allowance and the billed amount Mail order drug program, 31 to 90-day supply: • Generic: $10 copayment per prescription • Preferred brand name (formulary): $80 copayment per prescription and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained	Network pharmacy, up to a 30-day supply*: • Generic: $10 copayment per prescription • Preferred brand name (formulary): 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained • Non-Preferred brand name (non-formulary): 75% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained Foreign pharmacy, up to a 90-day supply: • $10 copayment for each 30-day supply Non-network pharmacy and paper claims for prescriptions filled at a network pharmacy: • All charges Mail order drug program, 31 to 90-day supply: • Generic: $30 copayment per prescription • Preferred brand name (formulary): 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless a brand exception is obtained • Non-Preferred brand name (non-formulary): 75% of the Plan's allowance, and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained

Covered medications and supplies - continued on next page

Benefits Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Value Plan**
	• Non-Preferred brand name (non-formulary): $120 copayment per prescription and any difference between our allowance and the cost of a generic equivalent, unless a brand exception is obtained	
Specialty drugs: • are used to treat chronic complex conditions and require special handling and close monitoring. • **must** be obtained from CVS Caremark Specialty Pharmacy. Call us at 1-800-410-7778 if you have any questions regarding preauthorization, quantity limits, or other issues. We can help you understand the preauthorization process, the kinds of drugs that are considered to be specialty drugs, the kinds of medical conditions they are used for, and other questions you may have. Also, see the description of specialty drugs in this Section. Note: Preauthorization for specialty drugs is required. Call us at 1-800-410-7778. See *Other services* under *You need prior Plan approval for certain services,* Section 3.	CVS Caremark Specialty Pharmacy: • 30-day supply: 15% of the Plan's allowance, limited to $200 per prescription • 90-day supply: 15% of the Plan's allowance, limited to $425 per prescription	CVS Caremark Specialty Pharmacy: • 50% of the Plan's allowance
Flu vaccination program This program covers the flu vaccine when obtained from a flu shot network pharmacy To find a participating flu shot pharmacy, visit our website, www.MHBP.com, or call 1-866-623-1441.	Flu shot network pharmacy: Nothing (No deductible) Non-Flu shot network pharmacy: All charges	Flu shot network pharmacy: Nothing (No deductible) Non-Flu shot network pharmacy: All charges
Medicines to promote better health as recommended under the Patient Protection and Affordable Care Act, limited to: • Iron supplements for children from age 6 months through 12 months • Oral fluoride supplements for children from age 6 months through 5 years • Folic acid supplements, 0.4 mg to 0.8 mg, for women capable of pregnancy • Aspirin for men age 45 through 79 and women age 55 through 79 • Vitamin D for members age 65 and older	Network retail pharmacy: Nothing Non-Network retail pharmacy: All charges	Network retail pharmacy: Nothing Non-Network retail pharmacy: All charges

Covered medications and supplies - continued on next page

Benefits Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Value Plan**
• Preparatory medications and supplies for covered colorectal cancer screening To receive benefits, you must use a Network retail pharmacy and have a written prescription from your physician. Medicines will be dispensed in up to a 30-day supply or the recommended prescribed limit, whichever is less. Note: Benefits are not available for non-aspirin pain relievers such as acetaminophen, ibuprofen or naproxen sodium based products.	Network retail pharmacy: Nothing Non-Network retail pharmacy: All charges	Network retail pharmacy: Nothing Non-Network retail pharmacy: All charges
Women's contraceptive drugs and devices that require a physician's written prescription, limited to: • generic oral contraceptive drugs and brand name oral contraceptive drugs that do not have a generic equivalent • contraceptive hormonal patches Note: Brand name oral contraceptive drugs that have a generic equivalent are covered as described on page xxx.	Network retail pharmacy, up to a 30-day supply: Nothing Mail order drug program, 31 to 90-day supply: Nothing Non-network retail pharmacy: All charges	Network retail pharmacy, up to a 30-day supply: Nothing Mail order drug program, 31 to 90-day supply: Nothing Non-network retail pharmacy: All charges
Women's prescription and over-the-counter emergency oral contraceptive drugs, with a physician's written prescription, limited to generic drugs and brand name drugs that do not have a generic equivalent. Note: Brand name oral contraceptive drugs that have a generic equivalent are covered as described on page xxx.	Network retail pharmacy: Nothing Non-network retail pharmacy: All charges	Network retail pharmacy: Nothing Non-network retail pharmacy: All charges
Women's contraceptive devices that require a physician's written prescription, limited to: • diaphragms • cervical caps • vaginal rings Note: These devices are not available through our mail order drug program.	Network retail pharmacy: Nothing Non-network retail pharmacy: All charges	Network retail pharmacy: Nothing Non-network retail pharmacy: All charges
Physician-prescribed over-the-counter or prescription drugs approved by the FDA to treat tobacco dependence	Network retail pharmacy: Nothing Non-network retail pharmacy: All charges	Network retail pharmacy: Nothing Non-network retail pharmacy: All charges
Not covered: • *Drugs and supplies for cosmetic purposes** • *Prescriptions written by a non-covered provider*	*All charges*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You pay	
Covered medications and supplies (cont.)	**Standard Option**	**Value Plan**
• *Vitamins, nutrients and food supplements that do not require a physician's prescription, even if a physician prescribes or administers them, except as indicated* • *Total parenteral nutrition (TPN) products and related services* • *Nonprescription drugs or medicines* • *Anorexiants or weight loss medications** • *Erectile dysfunction drugs** • *Drugs and supplies when another insurance plan or payor provides benefits, regardless of actual payment, for these services/supplies except Medicare Part B covered drugs and supplies (see Durable medical equipment, Section 5(a), for Medicare covered diabetic supplies)* • *Any amount in excess of the cost of the generic drug when a generic is available and a brand exception has not been obtained by the prescribing physician* • *Drugs for which preauthorization has been denied* • *Drugs obtained from a retail pharmacy in excess of a 30-day supply, except maintenance medications obtained at a CVS retail pharmacy* • *Drugs obtained from a foreign pharmacy in excess of a 90-day supply* ** Note: See Discount drug program, Section 5 (h)*	*All charges*	*All charges*

Section 5(g). Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) dental plan, your FEHB Plan will be the first/ primary payor of any benefit payments and your FEDVIP plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with Medicare and other coverage*.
- The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
  - The Standard Option calendar year deductible is $400 per person ($800 per family) for services of Network providers and $600 per person ($1,500 per family) for services of Non-Network providers.
  - The Value Plan calendar year deductible is $600 per person ($1,200 per family) for services of Network providers and $900 per person ($1,800 per family) for services of Non-Networkproviders.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with Medicare and other coverage.

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

Benefit description	You Pay After the calendar year deductible…	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Accidental injury benefit	**Standard Option**	**Value Plan**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. The services and supplies must be provided within one year of the accident and the patient must be a member of the Plan at the time services are rendered. Masticating (chewing) incidents are not considered to be accidental injuries.	Network: See *Accidental injury,* Section 5(d) Non-Network: 30% of the Plan's allowance and any difference between our allowance and the billed amount	Network: 20% of the Plan's allowance Non-Network: 40% of the Plan's allowance and any difference between our allowance and the billed amount
Oral surgery	**Standard Option**	**Value Plan**
Removal of impacted teeth.	See *Oral and maxillofacial surgery,* Section 5(b)	See *Oral and maxillofacial surgery,* Section 5(b)

Benefit description	You Pay After the calendar year deductible…	
Dental benefits	**Standard Option**	**Value Plan**
We have no other dental benefits	All charges	All charges

Section 5(h). Special features

Special feature	Description
Clinical Management programs	We administer several programs that work with your health benefits to promote better care outcomes: • Case management program • Flexible benefits option • Disease management program • Disease management incentive program
Case Management program	Case management services are designed to assist members and their families and physicians address acute, complex and/or long term medical needs. A professional case manager can assess the member's needs and, when appropriate, coordinate, evaluate, and monitor the member's care. Case management is a voluntary program provided at no additional cost. As a participant in our case management program, members have the right to: • Be educated about their rights; • Be informed of choices regarding services; • Have input into the case management plan; • Refuse treatment or services, including case management services and the implications of such refusal relating to benefits eligibility and/or health outcomes; • Use end of life and advance care directives; • Obtain information regarding the organization's criteria for case closure; • Receive notification and a rationale when case management services are changed or terminated; and • Obtain information on alternative approaches when the consumer, family and/or caregiver is unable to fully participate in the assessment phase. • File a complaint regarding the case management program by contacting MHBP Customer Service by phone at 1-800-410-7778 or by writing to MHBP, PO Box 8402, London, KY 40742. Members have the responsibility to: • Accurately and completely disclose relevant information and notify Coventry Health Care of any changes. • Become involved in individually specific health care decisions. • Work collaboratively with Coventry Health Care representatives in developing goals and implementing interventions to manage their condition. • Work collaboratively with health care providers in developing and carrying out agreed-upon treatment plans. • Make a good-faith effort to maximize healthy habits, such as exercising, not smoking and eating a healthy diet. • Abide by the administrative and operational procedures of our case management program If you feel you would benefit from case management services or would like more information about case management, please call us at 1-800-410-7778.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services.

	We may identify medically appropriate alternatives to regular contract benefits and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Disease management program	We provide programs to help members adopt effective self-care habits to improve their self-management of diabetes; asthma; chronic obstructive pulmonary disease (COPD); coronary artery disease; congestive heart failure; and certain rare conditions. You may receive information from us regarding the programs available to you in your area. Disease management is a voluntary program designed to help you manage a chronic condition successfully with outpatient treatment and avoid unnecessary emergency care or inpatient admissions. A case manager will work closely with you to provide you with educational information about your condition, treatment plan or medication support. As always, your final treatment plan will be decided between you and your physician. If you have a chronic condition and would like more information, or if you have questions about your current treatment, call us at 1-800-410-7778. As a member, you have certain rights and responsibilities related to the disease management program. Your rights include: • The right to know about philosophy and characteristics of the disease management program; • The right to have personally identifiable health information shared by the disease management program only in accordance with state and federal law; • The right to identify the staff member and their job title, and to speak with a supervisor of the staff member if requested; • The right to receive accurate information from the disease management program; • The right to receive administrative information regarding changes in or termination of the disease management program; • The right to decline participation, revoke consent or dis-enroll at any point in time; Your responsibilities include: • The responsibility to submit any forms that are necessary to participate in the program, to the extent required by law;

	• The responsibility to give accurate clinical and contact information and to notify the disease management program of changes in this information; and • The responsibility to notify the treating physician of their participation in the disease management program (if applicable).
Diabetes management incentive program	MHBP offers a wellness incentive program for members with diabetes. The program will reward members with a $50 credit toward your medical deductible in 2016. To be eligible, MHBP must be your primary payor for health benefits and you must: • Obtain all of the following medical services during 2015 to monitor your diabetes: - routine physical examination - hemoglobin A1C blood test - LDL test - dilated retinal eye exam • Maintain diabetic medication compliance throughout 2015 • Continue your MHBP enrollment for 2016 For more information on this incentive program, please contact us at 1-800-410-7778.
Health Risk Assessment	MHBP offers a free confidential Health Risk Assessment questionnaire online at www.MHBP.com. The questionnaire asks questions about nutrition, weight, physical activity, stress, safety and mental health. Each member who completes the HRA questionnaire receives a lifestyle score and personalized summary that helps them understand/identify potential risks to their physical and mental health. The results will direct them to digital coaching programs that address their most prevalent risks. Our confidential online digital coaching programs are comprised of four parts: consultation, planning, tools and resources and follow-up to help members set and reach attainable healthy lifestyle goals in areas such as: • Blood Pressure Management • Cholesterol Management • Depression Management • Nutrition Improvement • Physical Activity • Sleep Improvement • Stress Management • Weight Management
Personal Health Record	The new MHBP Personal Health (PHR) record provides members a dashboard view of their health. Members can view, track and add personal health data and use personalized tools and health information to proactively manage their health care. Access the PHR through the secure member portal at www.MHBP.com.
ExtraCare® Health card	The ExtraCare® Health Card is a value-added program through CVS Caremark that gives you a 20 percent discount on thousands of eligible CVS/pharmacy brand health-related items, from cough and cold medicine to pain and allergy relief. The card is different from your MHBP ID card and is mailed separately. This program is offered at no additional charge to you. Use your ExtraCare® Health Card at any CVS pharmacy store nationwide or online at www.CVS.com.

Discount drug program	MHBP members can receive a discount on certain drugs prescribed for cosmetic purposes, weight loss and impotency. You pay 100% of the discounted price at a network retail pharmacy. Call CVS Caremark at 1-866-623-1441 to determine whether your drug qualifies for a discounted price.
Round-the-clock member support	We provide integrated health benefit services including a national provider network, clinical management services, a national transplant program, a disease management program with round-the-clock benefits support, pharmacy network and plan administration. You can call us toll-free at any time, day or night, escept major holidays, to: • Initiate the precertification or preauthorization process • Get assistance in locating network providers • Obtain general health care information • Have your questions about health care issues answered This 24/7 service is a benefit to you, allowing you to be informed about your health care options. There is no penalty for not using it. If you have questions about any of the programs, your benefits or would like general health information, call us at 1-800-410-7778, 24 hours a day, 7 days a week, except major holidays.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and **you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs are the responsibility of the Plan, and all appeals must follow our guidelines. For additional information contact us at 1-800-410-7778 or visit our website, www.MHBP.com.

The MHBP Dental and Vision Plans

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

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

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

All FEHBP members are eligible for this comprehensive and flexible dental coverage at affordable group rates. Benefits increase after your first and second years of enrollment, and you don't have to wait until Open Season to enroll. From the start, you can receive benefits up to $2,000 per person every year. With nearly 183,000 DentalGuard Preferred Select Network locations to choose from, and the convenience of automatic claims filing, it's easy, too! So joining right now pays off.

Summary of MHBP Dental Plan Network Benefits*

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

*Non-Network Benefits are also available and are slightly lower.

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

Summary of MHBP Vision Plan Network Benefits

Benefit Category	Frequency (based on calendar year)	Copayment	Coverage from a VSP Network Doctor
Exam	12 months	$10	Covered in full
Lenses*	12 months	$10 (applies to lenses and frame)	Single vision, lined bifocal and lined trifocal lenses covered in full
Frame*	24 months	$10 (applies to lenses and frame)	Frame of your choice covered up to $120
Contact lenses*	12 months	None	$120 allowance

*You may choose either glasses or contact lenses

When you use VSP's nationwide Choice network you get:

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

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

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

- **Discount prices** on 1,000-plus brand-name hearing aids from several industry-leading manufacturers
- **Low-Price Guarantee*** – If you should find a lower price at another local provider, we'll gladly beat that price by 5%
- **60-day no-risk trial period** – if you are not satisfied, return your hearing aids within the trial period for a 100% refund
- **1 year follow-up care** – cleaning, adjustment and other hearing aid services, included in the price of your hearing aid
- **3-Year warranty** – one of the longest you'll find anywhere—on most hearing aids, covering repairs, loss and damage**
- **Free batteries** - two year supply mailed directly to your home (maximum of 160 cells per hearing aid)

Call **1-888-901-0129**, or visit www.HearPO.com/MHBP. One of our friendly representatives will explain the HearPO process and assist you in scheduling your appointment with a hearing care provider.

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

EyeMed Vision Care Program: Save up to 40% with your EyeMed Vision Care discount program. Members are eligible for discounts on exams, glasses and contact lenses at thousands of providers nationwide. Members have access to over 58,000 providers including optometrists, ophthalmologists, opticians and leading optical retailers such as: LensCrafters, Sears Optical, Target Optical, JCPenney Optical, participating Pearle Vision locations and many independents. For more information concerning the program or to locate a participating provider, visit the Plan's website, www.MHBP.com, or call 1-866-559-5252 and refer to plan id# 9235631.

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

QualSight LASIK offers a national network of credentialed physicians who have collectively performed more than 4 million procedures, the convenience of over 800 locations to provide easy and convenient access. Member savings represent 40% to 50% off the overall national average price of Traditional LASIK and significant savings are also provided on newer technologies such as Custom LASIK and Bladeless LASIK (IntraLase). Call 1-877-306-2010 for your free consultation and to see if you are a candidate for one of these life changing procedures.

QualSight LASIK pricing per procedure (per eye)*	LASIK only[1, 2]	LASIK[1, 2] with Lifetime Assurance Plan	LASIK with IntraLase[2]	LASIK with Lifetime Assurance Plan and IntraLase[2]
Traditional	$ 895	$ 1,295	$ 1,345	$ 1,695
Custom	$ 1,320	$ 1,595	$ 1,770	$ 1,995

**Provider participation may vary. [1]Pricing includes all FDA-approved procedures (no additional charges for astigmatism or higher amounts of correction) and surface ablation procedures (PRK, LASEK, Epi-LASIK) as necessary, and as offered at individual network practices. [2]When offered by participating network providers.*

Weight Watchers®: MHBP is proud to bring you a special offer on a 3-month subscription to Weight Watchers Online. It's only $55* for three months! To take advantage of this special offer, simply complete the following:

1. Go to www.weightwatchers.com/signup
2. Click "Enter Promotion Code" and enter code 8-334-791-17805 in the Promotion code box and click "Apply Code"
3. The payment plan box will display the 3-Month Online subscription offer for $55
4. Follow the remaining steps for setting up your account

You must be a MHBP member to take advantage of this special savings on Weight Watchers Online.

**You pay our current corporate rate for a 3-month prepayment plan for Weight Watchers Online. You must enter the code in the URL indicated above in order to take advantage of this offer. In addition to saving over our standard monthly plan pricing, you will receive an additional $10 savings off our current 3-month prepayment plan rate. The offer for the additional $10 off is only valid for new and returning Weight Watchers Online subscribers in the U.S. To qualify for savings you must complete the full term of the 3-month prepayment plan. Your subscription will be automatically renewed at the end of your plan period at the standard monthly rate (currently $16.95) until you cancel. Void where prohibited. This offer cannot be transferred, combined with other offers, or redeemed for cash.*

Section 6. General exclusions – services, drugs and supplies we don't cover

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

We do not cover the following:

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

- Treatment of learning disorder or specific delays in development, treatment of mental retardation or intellectual disability.
- Treatment of binge eating disorder or gambling disorder.
- Applied behavioral analysis (ABA) therapy.
- Travel, even if prescribed by a doctor, except as provided under the Aetna Institutes of Excellence transplant program or Ambulance benefit.
- Handling charges, administrative charges or late charges, including interest, billed by providers of care; charges for medical records; fees for missed appointments.
- Genetic counseling and/or genetic screening (see *Definitions*, Section 10).
- Home test kits, except for covered diabetic testing kits and supplies for patients with the established diagnosis of diabetes and home INR (International Normalized Ratio) monitor and testing materials used in conjunction with anticoagulation therapy.
- Services and/or supplies not listed as covered in this brochure.
- "Never Events" are errors in patient care that can and should be prevented. We will follow the policy of the Centers for Medicare and Medicaid Services (CMS). The Plan will not cover care that falls under these policies. For additional information, visit www.CMS.gov, enter Never Events into SEARCH.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

How to claim benefits

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

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

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

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

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

In addition:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.

Medical claims

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

MHBP Medical Claims
PO Box 8402
London, KY 40742

Prescription drug claims

Claims for covered prescription drugs and supplies that are not ordered through the mail order prescription drug program or not purchased from and electronically filed with a participating CVS/Caremark network pharmacy must include receipts that show the prescription number, NDC number (included on the bill), name of drug or supply, prescribing physician's name, date, charge and name and address of the pharmacy.

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

CVS Caremark
Attn: Claims Department
PO Box 52196
Phoenix, AZ 58072-2196

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

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

Overseas (foreign) claims

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

- We will provide translation and currency conversion services for claims for overseas (foreign) services.
- For inpatient hospital services, the exchange rate will be based on the date of admission. For all other services, we will apply the exchange rate for the date the services were rendered.
- All foreign claim payments will be made directly to the enrollee except for services rendered to beneficiaries of the United States Department of Defense third party collection program.
- Canceled checks, cash register receipts, or balance due statements are not acceptable.

Post-service claim procedures

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

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

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Records

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

Deadline for filing your claim

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

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

Direct Payment to hospital or provider of care

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

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

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if we do not receive the requested information within 60 days. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

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

Authorized representative

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

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning).

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.MHBP.com.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to us at MHBP, PO Box 8402, London, KY 40742 or by calling us at 1-800-410-7778.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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

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

b) Send your request to us at: MHBP, PO Box 8402, London, KY 40742; and

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

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

e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 4.

2 In the case of a post-service claim, we have 30 days from the date we receive your request to:

a) Pay the claim, or

b) Write to you and maintain our denial, or

c) Ask you or your provider for more information.

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

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

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

You must write to OPM within

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

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

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

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

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

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that can not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-800-410-7778. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at 202-606-3818 between 8 a.m. and 5 p. m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage".

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at www.NAIC.org.

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

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit, or up to the member's responsibility as determined by the primary plan if there is no adverse effect on you (that is, you do not pay any more), whichever is less. We will not pay more than our allowance. The combined payment from both plans may be less than (but will not exceed) the entire amount billed by the provider.

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

If you (the enrollee or any covered family member) receive (or are entitled to) a monetary recovery from any source as the result of an accidental injury or illness, you are required to reimburse us out of that recovery for any and all of our benefits paid to diagnose and treat that illness or injury. This is known as our reimbursement right.

The Plan may also, at its option, pursue recovery on your behalf, which includes the right to file suit and make claims in your name. This is known as our subrogation right.

The following are examples of situations to which our right to subrogate or to assert a right of reimbursement applies:

- When you are injured on premises owned by a third party; or
- When you are injured and benefits are available to you under any law or under any type of insurance, including but not limited to:
  - No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to this Plan
  - third party liability coverage
  - uninsured and underinsured motorist coverage
  - Workers' Compensation benefits
  - medical reimbursement or payment coverage

Our reimbursement right applies even if the monetary recovery may not compensate you fully for all of the damages resulting from the injuries or illness. In other words, we are entitled to be reimbursed for those benefit payments even if you are not "made whole" for all of your damages by the compensation you receive.

Our right of reimbursement is not subject to reduction for attorney's fees under the "common fund" doctrine without our written consent. We are entitled to be reimbursed for 100% of the benefits we paid on account of the injuries or illness unless we agree in writing to accept a lesser amount.

We enforce this right of reimbursement by asserting a first priority lien against any and all recoveries you receive by court order or out-of-court settlement, insurance or benefit program claims, or otherwise, without regard to how it is characterized, for example as "pain and suffering."

You must cooperate with our enforcement of our right of reimbursement by:

- telling us promptly whenever you have filed a claim for compensation resulting from an accidental injury or illness and responding to our questionnaires;
- pursuing recovery of our benefit payments from the third party or available insurance company;
- accepting our lien for the full amount of our benefit payments;
- signing our Reimbursement Agreement when requested to do so;

- agreeing to assign any proceeds or rights to proceeds from third party claims or any insurance to us;
- keeping us advised of the claim's status;
- advising us of any recoveries you obtain, whether by insurance claim, settlement or court order, and;
- promptly reimbursing us out of any recovery received to the full extent of our right of reimbursement.

Failure to cooperate with these obligations may result in the temporary suspension of your benefits and/or offsetting of future benefits.

For more information about this process, please call our Third Party Recovery Services unit at 202-683-9140.

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

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

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

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

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

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We do not offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans. See *Medicare Advantage (Part C)*.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.SocialSecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. This notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**.

When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

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

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

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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

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

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

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

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

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

Standard Option

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

Note: We will not waive the copayments and coinsurance for prescription drugs.

Value Plan

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

Call us at 1-800-410-7778 or visit our website at www.MHBP.com/member-resources/medicare-coordination for more information about how we coordinate benefits with Medicare.

- **Tell us about your Medicare coverage**

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

- **Private contract with your physician**

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

- **Medicare Advantage (Part C)**

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

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

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

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

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

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

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

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

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

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

If you:

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

Then, for your inpatient hospital care:

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

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

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

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

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

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us at 1-800-410-7778.

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

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

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

When you are covered by Medicare Part A and it is primary:

- **Standard Option**: We will waive applicable per-admission copayments and coinsurance for inpatient hospital benefits, inpatient mental health/substance abuse benefits and nursing benefits.
- **Value Plan**: We will not waive any deductibles, copayments or coinsurance.

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

- **Standard Option**: When Medicare Part B is primary, we will waive applicable deductibles, copayments and coinsurance for surgical and medical services billed by physicians, durable medical equipment, orthopedic and prosthetic appliances, ambulance services and outpatient mental health/substance abuse services. We will not waive the copayment and/or coinsurance for prescription drugs.
  - If your physician accepts Medicare assignment, you pay nothing for services that both Medicare and we cover.
  - If your physician does not accept Medicare assignment, you pay the difference between Medicare's "limiting charge" or the physician's actual charge (whichever is less) and our payment combined with Medicare's payment.
- **Value Plan**: We will not waive any deductibles, copayments or coinsurance.
  - If your physician accepts Medicare assignment, you pay the difference (if any) between Medicare's allowed amount and our payment combined with Medicare's payment.
  - If your physician does not accept Medicare assignment, you pay the difference between Medicare's "limiting charge" or the physician's actual charge (whichever is less) and our payment combined with Medicare's payment.

Note: We will not waive the copayment and/or coinsurance for prescription drugs.

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

Section 10. Definitions of terms we use in this brochure

Accidental injury

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

Admission

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

Assignment

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

Calendar year

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

Clinical trials cost categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

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

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

Coinsurance

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

Congenital anomaly

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

Convenient care clinic

A small healthcare facility, usually located in a high-traffic retail outlet, with a limited pharmacy, that provides non-emergency health care on a walk-in basis. Examples include MinuteClinics in CVS retail stores and Take Care Health clinics at Walgreen's. Convenient care clinics are different from Urgent care centers (See *Urgent care center*, page xxx.)

Copayment

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

Cost-sharing

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

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

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

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

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

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

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

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

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

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

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

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

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

Hospice care program

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

Incurred

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

Inpatient care

Inpatient care is rendered to a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that the patient will remain at least overnight and occupy a bed. The hospital bills for inpatient room and board charges for each day (24 hour period) of the inpatient confinement as well as for hospital incidental services. Inpatient hospital benefits apply to services provided by the hospital during an inpatient admission.

This Plan uses InterQual criteria to evaluate the appropriateness of inpatient care services.

Medical emergency

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

Medical necessity

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

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

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

Mental health/substance abuse

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

Morbid obesity

morbidities such as diabetes, coronary artery disease, hypertension, hyperlipidemia, obstructive sleep apnea, pulmonary hypertension, weight-related degenerative joint disease, or lower extremity venous or lymphatic obstruction. Eligible members must be age 18 or older.

Observation care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are provided while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or whether the patient will be able to be discharged from the hospital. Observation services are commonly ordered for a patient who presents to the emergency room department and who then requires a significant period of treatment or monitoring in order to make a decision regarding their inpatient admission or discharge. Some hospitals will bill for observation room status (hourly) and hospital incidental services.

If you are in the hospital for more than a few hours, always ask your physician or the hospital staff if your stay is consider inpatient or outpatient. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services-including "observation care"- are actually outpatient care. Since observation services are billed as outpatient care, outpatient facility benefit levels apply and your out-of-pocket expenses may be higher as a result.

This Plan uses InterQual criteria to evaluate the appropriateness of observation care services.

Orthopedic appliance

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

Plan allowance

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

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

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

Participating provider allowance: If you receive services from a participating provider (*see Other Participating Providers*, page 10), the Plan's allowance will be the amount that the provider has negotiated and agreed to accept for the services and or supplies. Benefits will be paid at Non-Network benefit levels, subject to the applicable deductibles, coinsurance and copayments.

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

- For all dialysis services and all urine drug testing services, the Non-Network allowance is the maximum Medicare allowance for such services.
- For other than dialysis services and urine drug testing services, the following applies:

- If you receive care in an area that has a fully developed Network (one in which you have adequate access to a network provider), but you do not use a Network provider the Plan's allowance will be reduced to a rate that the Plan would have paid had you used a Network provider. This Non-Network allowance is based upon a fee schedule that represents an average of the Network fee schedules for a particular service in a particular geographic area. In industry terms, this is called a "blended" fee schedule. Member out-of-pocket costs resulting from the application of the blended rate fee schedule will be limited to no more than an additional $5,000 (not including applicable coinsurance or copayments) beyond the out-of-pocket costs (not including applicable coinsurance or copayments) that would have been incurred if the blended rate had not been applied to the claim. This limitation on such additional out-of-pocket costs is applicable separately (per occurrence) to inpatient or outpatient hospital or ambulatory surgical center services and separately (per occurrence) to surgical fees. Other services to which the blended rate fee schedule applies are not subject to this limitation. We encourage you to call the Plan before scheduling any outpatient hospital or ambulatory surgical center services and/or surgery so that we may assist you, if possible, in avoiding situations where the blended rate fee schedule will be applied.

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

- If you receive care in an area that does not have a fully developed network and use a Non-Network provider, the Non-Network allowance is the lesser of: (1) the provider's billed charge; or (2) the Plan's OON fee schedule amount. The Plan's OON fee schedule amount is equal to the 80th percentile amount for the charges listed in the Prevailing Healthcare Charges System or the Medicare Data Resources System administered by FAIR Health, Inc. if such a charge exists for the service or supply. If no FAIR Health charge exists, the OON fee schedule amount may be determined by using the iSight rate established by National Care Network. The OON fee schedule amounts vary by geographic area in which services are furnished.

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

Network retail pharmacy allowance: the amount negotiated by the Plan's pharmacy benefit manager with the pharmacy or pharmacy group at which the drug is purchased.

Non-Network retail pharmacy allowance: the guaranteed discounted price for the drug negotiated by the Plan in its contract with its pharmacy benefit manager.

Allowance for drugs provided by Network or Participating providers: the amount negotiated with each provider or provider group who participates in the respective network.

Allowance for drugs provided by Non-Network providers:

- The "blended" fee schedule amount as described above, if the drug is provided by a facility provider in a fully-developed network area
- 80% of the Average Wholesale Price (AWP) of the drug (or its equivalent if AWP data is no longer published), when

- the drug is provided by a non-facility provider (e.g., a physician)
- the drug is provided in a geographic area to which the blended fee schedule does not apply
- there is no blended fee schedule amount available

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

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

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

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

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

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

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

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

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

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

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

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

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

Us/We Us and We refer to MHBP (Mail Handlers Benefit Plan).

You You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees can save an average of about 30% on products and services they routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS: Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter medications, vision and dental expenses, and much more) for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider file claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse, if married) must be working, looking for work (income must be earned during the year), or attending school full time to be eligible for a DCFSA.

If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?	Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

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

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.
Dental insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. **Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit**.
Vision insurance	All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/healthcare-insurance/dental-vision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888- 3337 (TTY: 1-877-889-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

The Federal Long Term Care Insurance Program – *FLTCIP*

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

Summary of MHBP Standard Option benefits – 2015

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the calendar year medical deductible of $400 per person (Network)/$600 per person (Non-Network). And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-Network physician or other health care professional.

Standard Option Benefits	You pay	Page(s)
Medical services provided by physicians		
Diagnostic and treatment services provided in the office	Network: • Primary care physician: $20 copayment per office visit for adults; $10 copayment per office visit for dependent children through age 21; • Specialty physician: $40 copayment per visit • Diagnostic X-rays, laboratory services and other professional services: 10%* of the Plan's allowance Non-Network: • Primary care physician and Specialty physician: 30%* of the Plan's allowance and any difference between our allowance and the billed amount • Diagnostic X-rays, laboratory services and other professional services: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	xxx-xxx
Services provided by a hospital		
• Inpatient	Network: $200 copayment per admission and 15% of the Plan's allowance for hospital ancillary services (No deductible) Non-Network: $500 copayment per admission; 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)	xxx
• Outpatient	Network: 10%* of the Plan's allowance Non-Network: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	xxx
Emergency benefits		

Standard Option Benefits	You pay	Page(s)
• Accidental injury	Network: • Emergency room: $200 copayment per occurrence for the first five (5) visits; $600 copayment per occurrence for all subsequent visits • Urgent care center: $50 copayment per occurrence Non-Network: • Emergency room: $200 copayment per occurrence and any difference between our allowance and the billed amount for the first five (5) visits; $600 copayment per occurrence and any difference between our allowance and the billed amount for all subsequent visits • Urgent care center: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	xxx
• Medical emergency	Network: • Emergency room: $200 copayment* per occurrence for the first five (5) visits; $600 copayment* per occurrence for all subsequent visits • Urgent care center: $50 copayment per occurrence* Non-Network: • Emergency room: $200 copayment* per occurrence and any difference between our allowance and the billed amount for the first five (5) visits; $600 copayment* per occurrence and any difference between our allowance and the billed amount for all subsequent visits • Urgent care center: 30%* of the Plan's allowance and any difference between our allowance and the billed amount	xxx
Mental health and substance abuse treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	xxx-xxx
Prescription drugs	Network retail electronic: • Generic: $5 copayment per prescription • Preferred brand name: 30% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless preauthorized, limited to $200 per prescription	xxx-xxx

	• Non-Preferred brand name: 50% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless preauthorized, limited to $200 per prescription Non-Network retail and Network retail paper: 50% of the Plan's allowance and any difference between our allowance and the billed amount Mail order drug program: • Generic: $10 copayment per prescription • Preferred brand name: $80 copayment per prescription and any difference between our allowance and the cost of a generic equivalent unless preauthorized • Non-Preferred brand name: $120 copayment per prescription and any difference between our allowance and the cost of a generic equivalent unless preauthorized Specialty drugs: 15% of the Plan's allowance, limited to $200 per prescription for a 30-day supply; 15% of the Plan's allowance, limited to $425 per prescription for a 90-day supply	
Dental care	Accidental injury; Oral surgery	xxx
Special features	Case Management program; Flexible Benefits Option; Disease Management program; Diabetes Management incentive program; Health Risk Assessment; Personal Health Record; ExtraCare Health Card; Discount Drug program; Round-the-clock Member Support	xxx
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after your covered medical and prescription drug expenses total: • $6,000/person ($12,000/family) per calendar year, for services , drugs and supplies fromNetwork providers/facilities and pharmacies, combined • $9,000/person ($18,000/family) for services drugs and supplies from Non-Network providers/facilities and pharmacies, combined Some costs do not count toward this protection.	xxx

Summary of MHBP Value Plan benefits – 2015

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the calendar year medical deductible of $600 per person (Network)/$900 per person (Non-Network). And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-Network physician or other health care professional.

Value Plan Benefits	You pay	Page(s)
Medical services provided by physicians		
Diagnostic and treatment services provided in the office	Network: • Primary care physician: $30 copayment per office visit for adults; $10 copayment per office visit for dependent children through age 21 • Specialty physician: $50 copayment per office visit* • Diagnostic X-rays, laboratory services and other professional services: 20%* of the Plan's allowance Non-Network: • Primary care physician and Specialty physician: 40%* of the Plan's allowance and any difference between our allowance and the billed amount • Diagnostic X-rays, laboratory services and other professional services: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	xxx-xxx
Services provided by a hospital		
• Inpatient	Network: 20%* of the Plan's allowance Non-Network: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	xxx
• Outpatient (Non-surgical)	Network: 20%* of the Plan's allowance Non-Network: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	xxx
• Outpatient (Surgical)	Network: $300 copayment per occurrence Non-Network: 40%* of the Plan's allowance and any difference between our allowance and the billed amount	xxx

Value Plan Benefits	You pay	Page(s)
Emergency benefits		
• Accidental injury/Medical emergency	Network: • Emergency room: 20%* of the Plan's allowance for the first five (5) visits; 40%* of the Plan's allowance for all subsequent visits • Urgent care center: 20% of thePlan's allowance Non-Network: • Emergency room: 20%* of thePlan's allowance and any difference between our allowance and the billed amount for the first five (5) visits; 40%* of the Plan's allowance and any difference between our allowance and the billed amount for all subsequent visits • Urgent care center: 40%* of thePlan's allowance and any difference between our allowance and the billed amount	xxx
Mental health and substance abuse treatment	Your cost-sharing responsibilities are no greater than for other illnesses or conditions	xxx-xxx
Prescription drugs	Network retail electronic: • Generic: $10 copayment per prescription • Preferred brand name: 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless preauthorized • Non-Preferred brand name: 75% of the Plan's allowance, and any difference between our allowance and the cost of a generic equivalent unless preauthorized Network retail paper and Non-Network retail: All charges Mail order drug program: • Generic: $30 copayment per prescription • Preferred brand name: 45% of the Plan's allowance and any difference between our allowance and the cost of a generic equivalent unless preauthorized • Non-Preferred brand name: 75% of the Plan's allowance, and any difference between our allowance and the cost of a generic equivalent unless preauthorized Specialty drugs: 50% of the Plan's allowance	xxx-xxx

Value Plan Benefits	You pay	Page(s)
Dental care	Accidental injury; Oral surgery	xxx
Special features	Case Management program; Flexible Benefits Option; Disease Management program; Diabetes Management incentive program; Health Risk Assessment; Personal Health Record; ExtraCare Health Card; Discount Drug program; Round-the-clock Member Support	xxx
Protection against catastrophic costs (out-of-pocket maximum)	Nothing after your covered medical and prescription drug expenses total: • $6,750/ person ($13,500/family) per calendar year, for services, drugs and supplies from Network providers/facilities and pharmacies • $10,000/person ($20,000/family) for services from Non-Network providers/ facilities	xxx

2015 Rate Information

For 2015 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.