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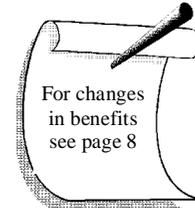
<http://www.pbp.org>

2005

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

Sponsored and administered by: The National League of Postmasters

Who may enroll in this Plan: All Federal Employees and annuitants who are eligible to enroll in the Federal Employee Health Benefits Program and who are or become League members or League Benefit Members.



To become a member or associate member: To be eligible for membership in the League, you must be an active or retired employee of the Federal Government or the United States Postal Service.

If you are a NON-postal employee/annuitant, you will automatically become an associate member of National League of Postmasters upon enrollment in the PBP Health Plan.

Annuitants (retirees) may enroll in this Plan and surviving spouses may continue in this Plan.

Membership dues: \$45 per year for Associate membership. The League will bill new Associate Members for the annual dues when it receives notice of enrollment. The League will also bill continuing Associate Members for the annual membership. Active and retired Postal Service employee's membership dues vary by League dues schedule. Only Postmaster members must pay dues based on level of office. Dues are paid by payroll deduction or annually at the option of the postal members. Continuing Postmaster members are billed for League membership dues annually or by payroll deduction as selected.

Enrollment codes for this Plan:

361 High Option – Self Only

362 High Option – Self and Family

364 Standard Option – Self Only

365 Standard Option – Self and Family

Authorized for distribution by the:



**United States
Office of Personnel Management**

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

RI 71-013



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. James".

Kay Coles James
Director



Notice of the United States Office of Personnel Management's Privacy Practices

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

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

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

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

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

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

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

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

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

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

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

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

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

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

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

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Introduction

This brochure describes the benefits of the PBP Health Plan under our contract (CS 1071) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This plan is underwritten by Union Labor Life and Gerber Life. The address for the PBP Health Plan administrative offices is:

PBP Health Plan
1019 N. Royal Street
Alexandria, Virginia 22314-1596

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, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

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

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 703-544-7111 and explain the situation.

If we do not resolve the issue:

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

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

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

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.

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

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 reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.html . The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/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.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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

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

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

We also have a Preferred Provider Organization (PPO) :

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. PBP Health Plan is solely responsible for the selection of PPO providers in your area. Contact us for the names of PPO providers and to verify their continued participation. You can also go to our Web page, which you can reach through the FEHB Web site, www.opm.gov/insure. Contact PBP Health Plan to request a PPO directory.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

How we pay providers

We make benefits payments to you or your provider, on your behalf. The benefit payment is the same in both cases. When we pay providers, our payment is based on the services they provide to you. We make no other payments to providers. Our payment policy does not include provider bonuses or financial incentives. Our payment policy does not encourage your provider to give any more or less medical care than your physical or mental condition requires.

Your Rights

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

- Compliance or licensing requirements: None apply
- Years in existence: 44
- Profit status: Non-profit

If you want more information about us, call 800-544-7111, or write to PBP Health Plan, 1019 North Royal Street, Alexandria, Virginia 22314-1596. You may also contact us by fax at 703-683-5411 or visit our Web site at www.pbp.org.

Section 2. How we change for 2005

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

Program-Wide changes

- In Section 3 under **Covered providers**, Alaska is designated as a medically underserved area in 2005. Maine, Utah and West Virginia are no longer designated as medically underserved areas in 2005.
- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan

Your share of the non-Postal premium will decrease by -5.3% for Self Only, or by -5.6% for Self and Family.

Both Options

- We added coverage up to \$700 per person per year for wigs for cancer victims.
- We added a **“24-Hour MultiPlan PPO Referral Hotline”** at 1-800-672-2140.
- We added a **“Healthier FEDS” Lifestyle MAYO CLINIC** program nationwide.
- We set a dollar limit of \$10,000 per person per year for DME wheelchairs.
- We allow wheelchair replacements once every three (3) years.
- We capped ESRD at 150% Allowance of MEDICARE rates for dialysis.
- We will waive this limit for those ESRD Members living over 100 miles from contracted ESRD centers.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-544-7111 or write us at PBP Health Plan, 1019 North Royal Street, Alexandria, Virginia 22314-1596. You may also request replacement cards through our website: www.pbp.org.

Where you get covered care

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

• Covered providers

We consider the following to be covered providers when they perform services within the scope of their license or certification: licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.). Other covered providers include: a licensed doctor of podiatry (D.P.M.); a licensed dentist (D.D.S or D.M.D.); licensed chiropractor (D.C.); licensed or registered physical, occupational and speech therapists (R.P.T., R.S.T., R.O.T. and S.P.). Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, Certified Registered Nurse Anesthetist (C.R.N.A.), nurse practitioner/clinical specialist and nursing school administered clinic; pastoral counselors in certain situations.

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are “medically underserved”. For 2005, the states are: Alabama, Alaska, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, and Wyoming.

• Covered facilities

Covered facilities include:

- Free-standing ambulatory facility: An out-of-hospital facility such as medical, cancer, dialysis, or surgical center or clinic, and licensed outpatient facilities accredited by the Joint Commission on Accreditation of Healthcare Organization for treatment of substance abuse.
- Hospice: A facility whose staff must include a doctor and registered nurse (R.N.) and may include social worker, clergy, certified counselor, volunteers, clinical psychologists and physical or occupational therapists who are able to provide care 24 hours a day.
- Skilled nursing facility (No Coverage Unless Medicare Pays First)

An institution that (1) is operated pursuant to law and primarily engaged in providing the following services for patients recovering from an illness or injury: room, board and 24-hour-a-day nursing service by professional nurses; (2) is under the fulltime supervision of a doctor or registered nurse (R.N.); (3) maintains adequate medical records; and (4) has the services of a doctor available under an established agreement for 24 hours a day, if not supervised by a doctor.

- Rehabilitation facilities (No Coverage Unless Medicare Pays First)

An institution that: (1) meets the “hospital” definition as stated; or (2) provides a program for the treatment of alcohol or drug abuse and meets one of the following requirements: (a) is affiliated with a hospital under a contractual agreement with an established patient referral system; (b) is licensed, certified or approved as an alcohol or drug abuse rehabilitation facility by the State; or is accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or (3) provides occupational or physical therapy or skilled nursing services primarily or more extensively than an acute hospital defined above.

- Hospital

(1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organization, or

(2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors, with 24-hour-a-day nursing service and that is primarily engaged in providing for sick and injured inpatients: general care and treatment through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control, or specialized care and treatment through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those services.

What you must do to get covered care

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

- **Transitional care**

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

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

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

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

- **Hospital care**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-544-7111.

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

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

These provisions apply only to the benefits of 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 case, the hospitalized family member’s benefits under the new plan begin on the effective date of enrollment.

How to get approval for...

• Your hospital stay

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

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

Warning:

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

How to precertify an admission

- You, your representative, your doctor, or your hospital must call us at **1-866-218-8317** at least 48 hours before an admission.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
 - Enrollee's name and Plan identification number;
 - Patient's name, birth date, and phone number;
 - Reason for hospitalization, proposed treatment, or surgery;
 - Name and phone number of admitting doctor;
 - Name of hospital or facility; and
 - Number of planned days of confinement.
- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

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 your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then 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 ask us to approve the additional days.

What happens when you do not follow the Precertification rules

If no one contacted us, we will decide whether the hospital stay was medically necessary. If we determine that the stay was medically necessary, we will pay the inpatient charges, less the \$500 penalty.

- If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we precertified the admission but you remained 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.

Exceptions:

You do not need precertification in these cases:

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

• **Other services**

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

- Durable medical equipment - We must pre-approve the purchase of any covered durable medical equipment in excess of \$600. A letter of medical necessity must first be submitted to the Plan.
- Network mental health and substance abuse - We must pre-approve a treatment plan for covered network benefits. Advise your provider to fax a written treatment plan, for review and approval, to the attention of: PBP Mental Health Coordinator at 703-683-5411 (FAX only).
- PET Scan – We must pre-approve the benefits for PET scan services. Your provider must first provide a letter of medical necessity for review by the Plan.
- Morbid obesity – We must pre-approve surgical treatment. Your provider must first provide a letter of medical necessity and a written psychiatric evaluation for review by the Plan. Then fax the letter of medical necessity and written psychiatric evaluation to 703-683-5411. Only FAX letters, properly signed on the psychiatrist's letterhead will be accepted by PBP.

Section 4. Your costs for covered services

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

Copayments

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

Example: When you see your PPO physician you pay a copayment of \$8 per visit and when you go in the hospital, you pay \$250 per admission.

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 do not count toward any deductible.

The calendar year deductible is \$200 per person under High Option with PPO, \$500 per person under High Option Non-PPO and \$250 per person under Standard Option with PPO, \$600 per person under Standard Option Non-PPO. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach: \$500 under High Option with PPO, \$1,000 under High Option Non-PPO, \$600 under Standard Option with PPO, and \$1200 under Standard Option Non-PPO.

We also have separate deductibles for:

- Prescription drugs - \$90 for retail pharmacies per person, per year for both High Option and Standard Option.
- Dental - \$30 per person per year for High Option. There is no Standard Option deductible for Dental Benefits.
- Mental conditions/substance abuse –

	Standard Option		High Option	
	PPO	Non-PPO	PPO	Non-PPO
Per person	\$250	\$300	\$200	\$275
	or	or	or	or
Per family	\$500	\$600	\$400	\$550

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

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

Coinsurance

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

Example: Under High Option you pay 10% of our allowance for office visits to a network provider.

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

For example, under High Option, if your physician ordinarily charges \$100 for a service but routinely waives your 25% coinsurance, the actual charge is \$75. We will pay \$56.25 (75% of the actual charge of \$75).

Differences between our allowance and the bill

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

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

- PPO providers agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment when you use a preferred provider. Here is a High Option example about coinsurance: You see a PPO physician who charges \$150, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just - - 10% of our \$100 allowance (\$10). Because of the agreement, your PPO physician will not bill you for the \$50 difference between our allowance and his bill.
- Non-PPO providers on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance -- **plus** any difference between our allowance and charges on the bill. Here is a High Option example: You see a non-PPO physician who charges \$150 and our allowance is again \$100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 25% of our \$100 allowance (\$25) under High Option. Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the \$50 difference between our allowance and his bill.

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

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	\$150	\$150
Our allowance	We set it at: \$100	We set it at: \$100
We pay	90% of our allowance: \$90	75% of our allowance: \$75
You owe: Coinsurance	10% of our allowance: \$10	25% of our allowance: \$25
+Difference up to charge?	No: \$0	Yes: \$50
TOTAL YOU PAY	\$10	\$75

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

For those services with coinsurance, other than prescription drug services, we pay **100%** of the Plan allowance for the remainder of the calendar year after your catastrophic protection out-of-pocket expenses for the services shown below for the calendar year exceed \$5,000 (\$3,500 PPO) per person per year or \$5,500 (\$4,000 PPO) per family under **Standard Option** and \$3,500 (\$3,000 PPO) per person per year or \$4,000 (\$3,500 PPO) per family under **High Option**.

Catastrophic protection out-of-pocket expenses for the purposes of this benefit are:

Standard Option

- The 30% you pay for hospital room and board, or 10% you pay for hospital room and board if using a PPO;
- The 30% you pay for medical services or 9% if using a PPO;
- The 30% you pay for Emergency Room Treatment or 9% if using a PPO;
- The 30% you pay for hospital services or 9% if using a PPO;
- The 30% you pay for surgical services or 9% if using a PPO; and
- The 30% you pay for durable medical equipment.
- The 30% PPO and 50% you pay for morbid obesity.
- The balance you pay for non-network dialysis services.

High Option

- The 25% you pay for hospital room and board, or the 10% you pay for hospital room and board if using a PPO;
- The 25% you pay for medical services or 10% if using a PPO;
- The 25% you pay for Emergency Room Treatment or 10% if using a PPO;
- The 25% you pay for hospital services or 10% if using a PPO;
- The 25% you pay for surgical services or 10% if using a PPO; and
- The 25% you pay for durable medical equipment
- The 25% PPO and 45% you pay for morbid obesity
- The balance you pay for non-network dialysis services.

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

- Copayments;
- Deductibles;
- Prescription drug expenses;
- Expenses in excess of the Plan allowances or maximum benefit limitations;
- Expenses for mental conditions / substance abuse (See Section 5 (e));
- Expenses for dental care; and
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 11-12).

When Government facilities bill us

Facilities of the Department of Veteran 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.

If we overpay you

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

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

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care is 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 you owe under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the Medicare equivalent amount.

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

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

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

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

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

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

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

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

- If your physician **accepts** Medicare assignment, then you pay nothing for covered charges.
- If your physician **does not accept** Medicare assignment, then you pay the difference between the “limiting charge” or the physician’s charge (whichever is less) and our payment combined with Medicare’s payment.

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 your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

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

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and pages 90 and 91 for a benefits summary.)

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at **800-544-7111** or at our Web site at www.pbp.org.

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: Standard Option with PPO per person \$250, Standard Option with PPO per Family of \$600. Standard Option Non-PPO per person \$600 and Standard Option Non-PPO per Family of \$1200. High Option with PPO per person of \$200, High Option with PPO per Family of \$500. High Option Non-PPO per person of \$500 and High Option Non-PPO per Family of \$1,000. We added “(No deductible)” to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Benefits Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does <i>not</i> apply.</p>		
Diagnostic and treatment services	You pay - Standard Option	You pay - High Option
<p>Professional services of physicians</p> <ul style="list-style-type: none"> • In physician’s office, when billed charges are for an office visit, labs, x-rays or surgeries rendered by the physician during the visit • At home <p>Note: These services do not include services billed by independent laboratory or x-ray facilities or services billed by providers other than physicians</p>	<p>PPO: \$8 copayment (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Note: Copayment applies to both general care and specialist physicians.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p> <p>Note: Copayment applies to both general care and specialist physicians.</p>

Diagnostic and treatment services – Continued on next page

Diagnostic and treatment services – <i>continued</i>	You pay – Standard Option	You pay - High Option
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Medical consultations • Second surgical opinion • Cardiac rehabilitation • Initial inpatient examination of a newborn child covered under a family enrollment 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p>
Lab, X-ray and other diagnostic tests		
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • PET scan (requires Plan’s pre-approval) • Ultrasound • Electrocardiogram and EEG Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Preventive care, adult	You pay – Standard Option	You pay - High Option
<p>Routine screenings, limited to:</p> <ul style="list-style-type: none"> • Hepatitis vaccinations, when pre-approved by the Plan, for high-risk individuals. Call us at 1-800-544-7111 for information about pre-approval • Serim Pylo tests – Twice per year • Strep A tests – Twice per year • Chemstrip Micral tests – twice per year • Quick Vue Flu tests – Twice per year • Total Blood Cholesterol – Once every five years, age 20 and older • Physical exams- (including a complete history and workup) once every two years, age 13 through 39; and once every year, age 40 and above. • Chlamydial infection for sexually active females under 25 • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening - every five years starting at age 50 – Double contrast barium enema - every five years starting at age 50 – Colonoscopy screening - every ten years starting at age 50 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Routine Prostate Specific Antigen (PSA) test – One annually for men age 40 and older</p>	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>

Preventive care, adult – Continued on next page

Preventive care, adult – <i>continued</i>	You pay - Standard Option	You pay-High Option
<p>Routine pap test – One annually for women age 18 and older.</p> <p>Note: The office visit is covered if pap test is received on the same day; see Diagnosis and Treatment, above.</p>	<p>PPO: Nothing. (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing. (No deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	<p>PPO: Nothing. (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing. (No deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine – one annually • Pneumococcal vaccine, age 65 and older 	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Any difference between our allowance and the billed amount (No deductible)</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Any difference between our allowance and the billed amount (No deductible)</p>
<p><i>Not covered: Physical exams for school, sports, employment or travel</i></p>	<p><i>All charges.</i></p>	<p><i>All charges</i></p>

Preventive care, children	You pay - Standard Option	You pay – High Option
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics <p>Note: Covered for dependent children under age 22</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Any difference between our allowance and the billed amount (No deductible)</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Any difference between our allowance and the billed amount (No deductible)</p>
<ul style="list-style-type: none"> For well-child care charges for routine examinations, immunizations and care (to age 3) 	<p>PPO: Any difference between our \$125 calendar year allowance and the billed amount. (No deductible).</p> <p>Non-PPO: Any difference between our \$125 calendar year allowance and the billed amount. (No deductible).</p>	<p>PPO: Any difference between the \$150 calendar year allowance and the billed amount. (No deductible).</p> <p>Non-PPO: Any difference between the \$150 calendar year allowance and the billed amount. (No deductible).</p>
<ul style="list-style-type: none"> Examinations, limited to: <ul style="list-style-type: none"> --Examinations for amblyopia and strabismus – limited to one screening examination (ages 2 through 6) 	<p>PPO: \$15 copayment (No deductible)</p> <p>Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: \$10 copayment (No deductible)</p> <p>Non-PPO: 10% of the Plan allowance and any difference between our allowance and the billed amount</p>

Maternity care	You pay - Standard Option	You pay - High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery. See <i>Section 3, How you get care</i>, for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 72 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you, your representative, your doctor, or your hospital must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. There are no maternity benefits for circumcision. Surgical benefits may be available. 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Maternity care –Continued on next page

Maternity care – <i>continued</i>	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> Prenatal care 	<p>PPO: Nothing. (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Nothing. (No deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<ul style="list-style-type: none"> We cover routine sonograms during pregnancy to determine age and size. Stand-by doctor charges will be covered only if medically necessary treatment is actually rendered to the child by the doctor. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits Section 5 (c) and Surgery benefits Section 5 (b). 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered: Routine sonograms just to determine sex</i></p>	<p><i>All charges</i></p>	<p><i>All Charges</i></p>
Family planning		
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> Voluntary sterilization (See Surgical procedures Section 5 (b)) Surgically implanted contraceptives (such as Norplant) Injectable contraceptive drugs (Such as Depo provera) Intrauterine devices (IUDs) Diaphragms <p>Note: We cover oral contraceptives and patches under the prescription drug benefit Section 5(f).</p>	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> <i>Genetic counseling, Viagra or similar E.D. type drugs or ointments.</i> 	<p><i>All charges</i></p>	<p><i>All Charges</i></p>

Infertility services	You pay - Standard Option	You pay–High Option
<p>Diagnosis and treatment of infertility, including up to two ovulation tests per year, except as shown in <i>Not covered</i>.</p>	<p>PPO: 9% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Infertility services after voluntary sterilization</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>artificial insemination</i> – <i>in vitro fertilization</i> – <i>embryo transfer and (GIFT)</i> – <i>Intravaginal insemination (IVI)</i> – <i>Intracervical insemination (ICI)</i> – <i>Intrauterine insemination (IUI)</i> • <i>Services and supplies related to ART procedures.</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges.</i></p>	<p><i>All Charges</i></p>
Allergy care		
<ul style="list-style-type: none"> • Testing and treatment, including materials (such as allergy serum) • Allergy injections 	<p>PPO: 9% of the Plan allowance Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Treatment therapies	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 41.</p> <ul style="list-style-type: none"> • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT), when preauthorized by the Plan <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. Call 800-544-7111 for preauthorization. We will ask you to submit information that establishes that GHT is medically necessary. Ask us to authorize GHT before you begin treatment, otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Other services</i> under <i>How to get approved for...</i> in section 3.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapies (excluding ventilators) 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Cardiovascular, metabolic and pulmonary conditioning when we approve a supporting letter of medical necessity from your doctor.</p>	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Note: \$2000 accumulative maximum applies to alternative treatments, physical and occupational therapies, speech therapy, chiropractic and cardiovascular, metabolic and pulmonary conditioning.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Note: \$2000 accumulative maximum applies to alternative treatments, physical and occupational therapies, speech therapy, chiropractic and cardiovascular, metabolic and pulmonary conditioning.</p>

Treatment Therapies –Continued on next page

Treatment therapies - <i>continued</i>	You pay - Standard Option	You pay - High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Chelation therapy, except for acute arsenic, gold, lead or mercury poisoning.</i> • <i>Dialysis – hemodialysis and peritoneal dialysis. See Special features for covered benefits.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Physical and occupational therapies	You pay - Standard Option	You pay - High Option
<p>Services of each of the following:</p> <ul style="list-style-type: none"> • Qualified physical therapists and • Occupational therapists. 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Note: \$2000 accumulative maximum applies to alternative treatments, physical and occupational therapies, speech therapy, chiropractic and cardiovascular, metabolic and pulmonary conditioning.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Note: \$2000 accumulative maximum applies to alternative treatments, physical and occupational therapies, speech therapy, chiropractic and cardiovascular, metabolic and pulmonary conditioning.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 		
Speech therapy	You pay - Standard Option	You pay - High Option
<p>Speech therapy</p>	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Note: \$2000 accumulative maximum applies to alternative treatments, physical and occupational therapies, speech therapy, chiropractic and cardiovascular, metabolic and pulmonary conditioning.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Note: \$2000 accumulative maximum applies to alternative treatments, physical and occupational therapies, speech therapy, chiropractic and cardiovascular, metabolic and pulmonary conditioning.</p>

Hearing services (testing, treatment, and supplies)	You pay - Standard Option	You pay - High Option
<p>Hearing aids, including exams, tests and adjustments to hearing devices when necessitated by accidental injury or surgery</p> <p>Note: Must be obtained within 120 days of the surgery or injury</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>routine hearing testing</i> • <i>hearing aids, testing and examinations and batteries for them, except for accidental injury or surgery</i> 	<p><i>All charges.</i></p>	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)		
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts). 	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and examinations for them except as noted as covered</i> • <i>Eye exercises and orthoptics (visual training)</i> • <i>Radial keratotomy and other refractive surgery</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Foot care		
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Removal or treatment of corns, calluses, free edge of toenails, and foot subluxations</i> • <i>Foot orthotics or similar devices</i> • <i>Arch supports or similar devices</i> • <i>Orthopedic and corrective shoes</i> • <i>Heel pads and heel cups</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Orthopedic and prosthetic devices	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy. • Wigs for cancer victims only (up to \$700) <p>Note: See Section 5 (b) for coverage of the surgery to insert the device, and Section 5 (c) for inpatient and outpatient hospital charges.</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Lumbosacral supports</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Durable medical equipment (DME)	You pay - Standard Option	You pay - High Option
<p>Durable medical equipment (DME) is equipment and supplies that:</p> <ol style="list-style-type: none"> 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. <p>We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • Hospital beds; • Wheelchairs; • Crutches; and • Walkers. <p>Note: Call us at 866-218-8317 for information on how to get pre-approval for lease or purchase.</p> <p>Note: A purchase of durable medical equipment in excess of \$600 must be supported by a letter of medical necessity and pre-approved by the Plan to be covered.</p>	<p>PPO: Same as non-PPO (No deductible)</p> <p>Non-PPO: \$100 copayment per device and 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount for supplies received independently of a device.</p>	<p>PPO: Same as non-PPO (No deductible)</p> <p>Non-PPO: \$100 copayment per device and 25% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount for supplies received independently of a device.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Sun or heat lamps; heating pads;</i> • <i>Air conditioners, purifiers and humidifiers;</i> • <i>Wheelchair replacements provided less than three (3) years after the last one covered.</i> • <i>Exercise, safety, computer, communication and convenience equipment;</i> • <i>Whirlpools, saunas and similar household items</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Durable medical equipment (DME) – continued	You pay - Standard Option	You pay - High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Stair glides, ramps, liftchairs, elevators and other modifications or alterations to vehicles or households;</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Home health services		
<p>Nursing services and home health care when:</p> <ul style="list-style-type: none"> • A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • A home health aide, that is part of a home health care plan after discharge from covered hospital confinement provides the services • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed. 	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 30% of the Plan allowance and any difference between the \$10,000 per person, per year, maximum Plan payment and the billed amount</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 25% of the Plan allowance and any difference between the \$10,000 per person, per year, maximum Plan payment and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;</i> • <i>Private duty nursing care while confined in a hospital</i> 	<p><i>All charges.</i></p>	<p><i>All charges</i></p>

Chiropractic	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> Manipulative of the spine and extremities Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Note: \$2000 accumulative maximum applies to alternative treatments, physical and occupational therapies, speech therapy, chiropractic and cardiovascular, metabolic and pulmonary conditioning.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Note: \$2000 accumulative maximum applies to alternative treatments, physical and occupational therapies, speech therapy, chiropractic and cardiovascular, metabolic and pulmonary conditioning.</p>
Alternative treatments	You pay - Standard Option	You pay - High Option
<p>Acupuncture by a doctor of medicine, osteopathy, or licensed acupuncturist for anesthesia, pain relief, or therapeutic treatment</p>	<p>PPO: 9% of the Plan allowance and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Note: \$2000 accumulative maximum applies to alternative treatments, physical and occupational therapies, speech therapy, chiropractic and cardiovascular, metabolic and pulmonary conditioning.</p>	<p>PPO: 10% of the Plan allowance and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount and any difference between the \$2,000 per person, per year maximum Plan payment and the billed amount.</p> <p>Note: \$2000 accumulative maximum applies to alternative treatments, physical and occupational therapies, speech therapy, chiropractic and cardiovascular, metabolic and pulmonary conditioning.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Naturopathic services</i> <i>Long-term rehabilitative therapy, except speech therapy</i> <i>Maintenance cardiac rehabilitation</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Educational classes and programs		
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation <p>Note – Smoking cessation drugs and medications, including nicotine patches are not available under any other Plan provisions.</p> <ul style="list-style-type: none"> • Diabetes self-management. • MAYO CLINIC “LIFESTYLE COACHING” for stress, weight management, smoking cessation, exercise & related benefits. See “Special Features” section of this booklet. 	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Nothing (No deductible)</p> <p>Any amount over \$200 for one smoking cessation program per person per lifetime</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: Nothing (No deductible)</p> <p>Any amount over \$200 for one smoking cessation program per person per lifetime</p>

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: Standard Option with PPO: \$250 per person (\$600 per family) Standard Option non-PPO: \$600 per person (\$1,200 per family) High Option with PPO \$200 per person (\$500 per family) High Option Non-PPO: \$500 per person (\$1,000 per family) 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 non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**

Benefits Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</p>	

Surgical procedures	You pay - Standard Option	You pay - High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Surgical procedures - Continued on next page

Surgical procedures – <i>continued</i>	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Treatment of burns 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Assistant surgeons – We cover up to 20% of the Plan allowance for the primary surgeon’s charge 	<p>PPO: Nothing</p> <p>Non-PPO: Any difference between our allowance and the billed amount.</p>	<p>PPO: Nothing</p> <p>Non-PPO: Any difference between our allowance and the billed amount</p>
<p>When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, the plan allowance for all procedures after the primary procedure is half of the allowance the procedure would have if it were a primary procedure.</p> <p>Note: Multiple or bilateral surgical procedures performed through the same incision are “incidental” to the primary surgery, i.e., the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.</p>	<p>PPO: 9% of the Plan allowance for the primary procedure and any difference between our 50% allowance and the billed amount for subsequent procedures.</p> <p>Non-PPO: 30% of the Plan allowance for the primary procedure and any difference between our 50% allowance and the billed amount for subsequent procedures</p>	<p>PPO: 10% of the Plan allowance for the primary procedure and any difference between our 50% allowance and the billed amount for subsequent procedures</p> <p>Non-PPO: 25% of allowance for the primary procedure and any difference between our 50% allowance and the billed amount for subsequent procedures</p>
<p>Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. We must pre-approve surgery for benefit to be available.</p>	<p>PPO: 30% of the Plan allowance.</p> <p>Non-PPO: 50% of the Plan allowance and any difference between our allowance and the billed amount.</p>	<p>PPO: 25% of the Plan allowance.</p> <p>Non-PPO: 45% of the Plan allowance and any difference between our allowance and the billed amount.</p>

Surgical procedures - Continued on next page

Surgical procedures – <i>continued</i>	You pay - Standard Option	You pay - High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Services of a standby surgeon, except during angioplasty</i> • <i>All procedures associated with treatment of temporomandibular disorders</i> • <i>Assistant surgery services provided by a non-physician provider such as a Physician Assistant (P.A.), Certified Registered Nurse First Assistant (C.R.N.F.A.) and a Certified Surgical Technologist (C.S.T.)</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Reconstructive surgery	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. <p>Note: PBP pays 100% at MAYO Clinics.</p> <ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage) <p>Note: We pay for internal breast prostheses as hospital benefits when the hospital is billing for the prostheses.</p> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 72 hours after the procedure.</p>	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>

Reconstructive surgery – Continued on next page

Reconstructive surgery – continued	You pay - Standard Option	You pay - High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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 for the correction of congenital anomalies</i> • <i>Injections of silicone, collagens, botoxin, and similar substances</i> • <i>Surgeries related to sex transformation or sexual dysfunction or sexual inadequacy.</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Oral and maxillofacial surgery		
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of tori, leukoplakia or malignancies • Excision of cysts and incision of abscesses not involving the teeth • Other surgical procedures that do not involve the teeth or their supporting structures • Removal of impacted teeth <p>Note: When multiple or bilateral oral maxillofacial surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays the same benefits as indicated under Multiple surgical procedures for the above listed procedures.</p> <p>Note: Removal of impacted teeth are not considered multiple procedures.</p>	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth (other than impacted teeth) or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone – See dental benefits)</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Organ/tissue transplants	You pay - Standard Option	You pay - High Option
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Single lung • Double lung • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. • Bone marrow transplants and stem cell support as follows: <p><i>Allogeneic</i> bone marrow for acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkins lymphoma, advanced neuroblastoma (children over age one), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, thalassemia major, and Wiskott-Aldrich syndrome.</p> <p><i>Autologous</i> bone marrow transplants (autologous stem cell and peripheral stem support) for the following conditions: acute lymphocytic or nonlymphocytic leukemia; advanced Hodgkins lymphoma and advanced non-Hodgkins lymphoma; advanced neuroblastoma; testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; breast cancer, multiple myeloma; and epithelial ovarian cancer.</p>	<p>Nothing, if a MAYO Clinic is used.</p> <p>Any amount above the \$100,000 limit, if a hospital other than MAYO Clinic is used.</p> <p>See Sections 5 (a), 5 (b) and 5 (c) for the portion you pay.</p> <p>See National Transplant Program.</p>	<p>Nothing, if a MAYO Clinic is used.</p> <p>Any amount above the \$100,000 limit, if a hospital other than MAYO Clinic is used.</p> <p>See Sections 5 (a), 5 (b) and 5 (c) for the portion you pay</p> <p>See National Transplant Program.</p>

Organ/tissue transplants – Continued on next page

Organ/tissue transplants – <i>continued</i>	You pay - Standard Option	You pay - High Option
<p>Limited Benefits – Benefits apply only if we cover the recipient and are limited to \$100,000 per transplant. This limitation includes costs for hospitals; doctors; laboratory; radiology; medications; ancillary charges; pre-transplant examinations, tests, diagnosis and related charges; cadaver procurement; and any donor costs. We must approve all related expenses prior to the surgery, including charges for procurement of cadaver organs.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Nothing, if a MAYO Clinic is used.</p> <p>Any amount above the \$100,000 limit, if a hospital other than MAYO Clinic is used.</p> <p>See National Transplant Program.</p>	<p>Nothing, if a MAYO Clinic is used.</p> <p>Any amount above the \$100,000 limit, if a hospital other than MAYO Clinic is used.</p> <p>See National Transplant Program.</p>
<p>National Transplant Program-</p> <p>Limited to the following performed at one of the MAYO Clinics:</p> <ul style="list-style-type: none"> • Bone marrow • Heart • Kidney/pancreas • Liver • Heart/lung • Single lung • Double lung <p>MAYO Clinics are located in Rochester, Minnesota, and in Jacksonville, Florida, and in Phoenix, Arizona</p> <p>We pay pre-approved travel & hotel for the member and spouse and/or member and close friend or member and another family member. In sum, we pay for the member and one other person selected by the member to help give comfort and support.</p> <p>Note: Benefits include pre-approved transportation and lodging. Call us at 800-544-7111 for more details.</p>	<p>Nothing</p>	<p>Nothing</p>

Organ/tissue transplants – Continued on next page

Organ/tissue transplants – <i>continued</i>	You pay - Standard Option	You pay - High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Services or supplies for or related to organ/tissue transplants for any diagnosis not specifically listed as covered including chemotherapy and/or radiation therapy when supported by allogeneic or autologous bone marrow or stem cell transplants, drugs or medications administered to stimulate or mobilize stem cells for transplant, and all other services or supplies which are not medically necessary or appropriate but for the non-covered procedure.</i> • <i>Allogeneic and autologous bone marrow and stem cell transplants for solid tumors except as noted above.</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Anesthesia</p>		
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>	<p>PPO: 10% of Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p> <p>Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and billed amount.</p> <p>Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.</p>

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. In that case, we added “(calendar year deductible applies)”. The calendar year deductible is: For Standard Option with PPO, \$250 per person or \$600 per family. For Standard Option Non-PPO, \$600 per person or \$1,200 per family. For High Option with PPO, \$200 per person or \$500 per family. For High Option Non-PPO, \$500 per person or \$1,000 per family.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM \$500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

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Benefits Description	You pay	
Note: The calendar year deductible applies ONLY when we say below: “(calendar year deductible applies)”.		
Inpatient hospital	You pay - Standard Option	You pay - High Option
<p>Room and board, such as</p> <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. <p>Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital’s average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area.</p> <p>Note: When the non-PPO hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: \$250 per admission copayment and 30% of the Plan’s covered charges and any difference between our covered charges and the billed amount.</p> <p>Note: If you use a PPO provider and a PPO facility, we may still pay non-PPO benefits if you receive treatment from a radiologist, pathologist, or anesthesiologist that is not a PPO provider.</p> <p>Note: If you are hospitalized at the MAYO Clinics for an accepted covered transplant or an accepted complex surgery, you pay nothing.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: \$150 per admission copayment and 25% of the Plan’s covered charges and any difference between our covered charges and the billed amount.</p> <p>Note: If you use a PPO provider and a PPO facility, we may still pay non-PPO benefits if you receive treatment from a radiologist, pathologist, or anesthesiologist that is not a PPO provider.</p> <p>Note: If you are hospitalized at the MAYO Clinics for an accepted covered transplant or an accepted complex surgery, you pay nothing.</p>

Inpatient hospital – Continued on next page

Inpatient hospital - <i>continued</i>	You pay - Standard Option	You pay - High Option
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics • Take home items (including prescription drugs) Note: Medical supplies, appliances, medical equipment, and covered items billed by a hospital for use at home are covered under Section 5 (a) • Prosthetic devices such as artificial joints and pacemakers. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: \$250 per admission copayment and 30% of the Plan's covered charges and any difference between our covered charges and the billed amount.</p> <p>Note: If you are hospitalized at the MAYO Clinics for a covered transplant or an accepted complex surgery, you pay nothing..</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: \$150 per admission copayment and 25% of the Plan's covered charges and any difference between our covered charges and the billed amount.</p> <p>Note: If you are hospitalized at the MAYO Clinics for a covered transplant or an accepted complex surgery, you pay nothing.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board at the level they would have been covered if provided in an alternative setting</i> • <i>Custodial care; see definition.</i> • <i>Non-covered facilities, such as nursing homes, extended care facilities (except when Medicare A is primary) and schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> • <i>Surcharges made by hospitals</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Outpatient hospital or ambulatory surgical center	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics • Prosthetic devices such as artificial joints and pacemakers <p>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We cover dental procedures under the dental benefit. See Section 5 (h).</p>	<p>PPO: 9% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: 10% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>
Extended care benefits/Skilled nursing care facility benefits		
<p>No benefit unless covered under Medicare Part A. Once Medicare has made their primary payment, we provide secondary benefits for the appropriate Medicare Part A deductible and coinsurance in full.</p> <p>Note: Our coverage of any form of ventilation or respiratory therapy is limited to these benefit rules.</p>	<p>PPO: Nothing</p> <p>Non-PPO: Nothing</p>	<p>PPO: Nothing</p> <p>Non-PPO: Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Services and supplies for which Medicare Part A did not provide benefits</i> 	<p><i>All charges.</i></p>	<p><i>All charges</i></p>

Hospice care	You pay - Standard Option	You pay - High Option
<p>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 doctor.</p> <p>The hospice team may also include social workers, members of the clergy, certified counselors, volunteers, clinical psychologists, physical and occupational therapists.</p> <p>The hospice care program must begin after a person's primary doctor certifies terminal illness and life expectancy of six months or less. Hospice care must be:</p> <ul style="list-style-type: none"> • Ordered by the supervising doctor, and • Charged by the hospice care program, and • Provided within six months from the date the person entered (or re-entered after a period of remission) a hospice care program. <p>Note: If you are in remission and discharged from a hospice care program, a readmission within three months of a prior discharge is considered as part of the same period of care. A new period begins three months after a prior discharge with maximum benefits available.</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: Any difference between the Plan allowance and the billed amount</p> <p>Note: The Plan allowance is:</p> <ul style="list-style-type: none"> • \$300 per day up to \$3,000 per period of inpatient care • 100% of covered charges up to \$2,000 per period of outpatient care. 	<p>PPO: Same as non-PPO</p> <p>Non-PPO: Any difference between the Plan allowance and the billed amount</p> <p>Note: The Plan allowance is:</p> <ul style="list-style-type: none"> • \$300 per day up to \$3,000 per period of inpatient care • 100% of covered charges up to \$2,000 per period of outpatient care.
<p>Bereavement benefit:</p> <p>Family bereavement counseling and supportive services if the covered family members receive the services from a hospice care program within three months following the death of a covered family member who received hospice care benefits under the Plan.</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: Any difference between the \$250 Plan allowance and the billed amount</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: Any difference between the \$250 Plan allowance and the billed amount</p>
<p><i>Not covered:</i></p> <p><i>Independent nursing, homemaker</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>

Ambulance	You pay – Standard Option	You pay – High Option
<ul style="list-style-type: none"> Local professional ambulance service when medically appropriate 	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>

Section 5(d) Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: With Standard Option, \$250 per person or \$600 per family with PPO, With Standard Option non-PPO, \$600 per person or \$1,200 per family. With High Option with PPO, \$200 per person or \$500 per family. With High Option non-PPO, \$500 per person or \$1,000 per family
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings. We do not cover dental care for accidental injury.

Benefit Description	You pay After the calendar year deductible...	
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</p>		
Accidental injury	You pay - Standard Option	You pay - High Option
<p>If you receive care for your accidental injury within 72 hours, we cover:</p> <ul style="list-style-type: none"> • Non-surgical physician services and supplies • Related outpatient hospital services <p>Note: We pay Hospital benefits if you are admitted.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: The difference between the Plan allowance and the billed amount (No deductible)</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: The difference between the Plan allowance and the billed amount (No deductible)</p>

Accidental injury -- Continued on next page

Accidental injury - <i>continued</i>	You pay - Standard Option	You pay - High Option
<p>If you receive care for your accidental injury after 72 hours, we cover:</p> <ul style="list-style-type: none"> • Non-surgical physician services and supplies • Related outpatient hospital services <p>Note: We pay Hospital benefits if you are admitted. See Section 5 (c) for other hospital benefits and Section 5 (b) for surgical benefits.</p>	<p>PPO: 9% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount</p>
Medical emergency		
<p>Outpatient medical or surgical services and supplies provided in a hospital emergency room.</p>	<p>PPO: 9% of the Plan allowance and a \$50 copayment per access to care (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and a \$50 copayment per access to care and any difference between the sum of our allowance plus the copayment and the billed amount (No deductible)</p>	<p>PPO: 10% of the Plan allowance and a \$50 copayment per access to care (No deductible)</p> <p>Non-PPO: 25% of the Plan allowance and a \$50 copayment per access to care and any difference between the sum of our allowance plus the copayment and the billed amount (No deductible)</p>
Ambulance		
<p>Professional ambulance service provided for accidental injury is covered under the accidental injury benefit.</p> <p>When a patient is provided ambulance service to an outpatient hospital emergency room for a medical emergency (non-accidental), we will cover as indicated in this section.</p> <p>Note: We cover air ambulance only when it is medically necessary and the physician provides a letter of medical necessity.</p> <p>Note: See 5(c) for non-emergency service.</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p>	<p>PPO: Same as non-PPO</p> <p>Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p>

Section 5(e) Mental health and substance abuse benefits

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You may choose to get care In-Network or Out-of-Network. When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when a deductible does not 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 other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE IN-NETWORK SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 53 in this booklet.

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Benefits Description	You pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
In-Network Benefits	You pay
<p>All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. To request approval, advise your provider to fax a written treatment plan to the attention of: PBP Mental Health Coordinator at FAX Number: 703-683-5411</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>

In-Network benefits - <i>continued</i>	You Pay
<ul style="list-style-type: none"> Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers Medication management is paid as medical. See Section 5 (a) 	9% under Standard Option or 10% under High Option of our allowance, after a mental condition/substance abuse calendar year deductible of \$250 under Standard Option or \$200 under High Option.
<ul style="list-style-type: none"> Diagnostic tests – psychiatric Diagnostic tests – medical are paid as medical. See Section 5 (a) 	9% under Standard Option or 10% under High Option of our allowance, after a mental condition/substance abuse calendar year deductible of \$250 under Standard Option or \$200 under High Option.
<ul style="list-style-type: none"> Inpatient services provided by a hospital or other facility Inpatient services in approved alternative care settings 	10% of the Plan allowance
<ul style="list-style-type: none"> Outpatient Services provided by a hospital or other facility Outpatient Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	9% of the Plan allowance under Standard Option or 10% of the Plan allowance under High Option, after a mental condition/substance abuse calendar year deductible of \$250 under Standard Option or \$200 under High Option
<p><i>Not covered: Services we have not formally pre-approved.</i></p> <ul style="list-style-type: none"> <i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another</i> 	<i>All charges.</i>

Preauthorization To be eligible to receive these enhanced mental health and substance abuse benefits you must obtain a treatment plan and follow all of the following network authorization processes:

Advise your provider to fax a written treatment plan, for review and approval, to the attention of: PBP Mental Health Coordinator at FAX 703-683-5411 to initiate consideration of your case. To identify MultiPlan PPO network providers, call **1-800-672-2140**.

Network limitation If you do not obtain an approved treatment plan, we will provide only Out-of-Network benefits.

Catastrophic protection out-of-pocket limit

For those services with coinsurance, we pay 100% of the Plan allowance for the remainder of the calendar year after catastrophic protection out-of-pocket expenses for the mental health and substance abuse coinsurance for that calendar year exceed \$3,500 per person per year or \$4,000 per family under Standard Option and \$3,000 per person per year or \$3,500 per family under High Option.

Out-of-Network Benefits	You Pay
<p>For mental conditions, we cover inpatient doctor visits provided during a covered admission.</p>	<p>A \$300 annual deductible and 50% of the Standard Option plan allowance of a \$275 annual deductible and 20% of the High Option plan allowance, and any difference between our allowance and the billed charges.</p>
<p>For mental conditions, we cover inpatient room and board and other hospital charges for up to 100 days per covered person each calendar year.</p> <p>Note: For individual cases, we may agree to cover hospital day treatment (partial hospitalization) the same as inpatient care. We consider two admissions separated by less than 30 calendar days to be one admission.</p>	<p>A \$500 per admission copayment, 40% of the Standard Option Plan allowance or 30% of the High Option Plan allowance, and any difference between our allowance and the billed charges.</p>
<p>For mental conditions, we allow up to \$100 per visit for 25 outpatient visits per person per year.</p> <p>Note: Visits used to meet the deductible amount are not counted as part of the 25 visits.</p>	<p>A \$300 annual deductible and 50% of the Standard Option Plan allowance or a \$275 annual deductible and 50% of the High Option Plan allowance and any difference between our allowance and the billed charges.</p>
<p>For substance abuse, we cover hospital inpatient care and services, outpatient services and supplies, and rehabilitation. This benefit is limited to a maximum.</p>	<p>A \$500 annual deductible and 30% of the Plan allowance, and charges in excess of our allowance and the \$3,500 per person per year maximum benefit.</p>
<p><i>Not covered</i></p> <ul style="list-style-type: none"> • <i>Treatment related to marital discord</i> • <i>Personal comfort items such as telephone and television, guest meals and beds, barber and beauty services</i> • <i>Custodial Care (see page 79)</i> • <i>Treatment for learning disabilities and mental retardation</i> • <i>Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staffs</i> 	<p><i>All charges.</i></p>

Precertification

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

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

- Section 3, *How you get care*, for information about catastrophic protection for these benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting out-of-network claims.

Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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 annual drug deductible is \$90 per person for network or non-network retail pharmacies for both Standard Option and High Option. The annual drug deductible applies to almost all benefits in this section. We added “(No Deductible)” to show when the annual drug deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician or a licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy or our mail order program for maintenance medication. To locate a network pharmacy in your area, call BeneCard at 800-479-0031 or visit our website at www.pbp.org. Note: There are approximately 52,000 network pharmacies.
- **We use a formulary.** The formulary identifies preferred name brand drugs. Our formulary applies to drugs received from a network retail pharmacy or our mail order program. Your copayment is less for drugs listed on our formulary than for those drugs not listed.

We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800-479-0031.

- **These are the dispensing limitations.** We will cover up to a 30-day supply of covered drugs or supplies from network retail pharmacies or from non-network retail pharmacies. Call BeneCard at 800-479-0031 or visit our website at www.pbp.org to locate a network retail pharmacy in your area. If you fill a prescription at a non-network retail pharmacy, our benefit is based on the cost of the drug at a network retail pharmacy. Network pharmacies will not dispense a refill until enough time has passed for the prior prescription to be mostly used. You must present your prescription drug identification card when using a network retail pharmacy to receive network benefits. If you fail to present the card for any reason, non-network benefits will apply.

You may purchase up to a 90-day supply of maintenance drugs through the Mail Order Drug Program. The Mail Order Drug Program will not dispense drugs that require constant refrigeration, are too heavy to mail, or that must be administered in a clinical setting.

When a doctor prescribes different doses of the same medication on the same prescription, we consider each dose a new prescription; therefore a copayment would be required.

Prescription drug benefits begin on the next page

- The Mail Order Drug Program will dispense a generic equivalent drug if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs are the therapeutic equivalent of more expensive brand name drugs. Generic drugs are less expensive than the brand name drugs they replace. You may reduce your catastrophic protection out-of-pocket costs by choosing to use generic drugs.

When you do have to file a claim. There is no claim to file when a network retail pharmacy or the mail order program fills prescriptions. We will send you information on the mail order drug program and how to file a claim for non-network retail pharmacies. You must complete the initial mail order form, enclose your prescription and copayment, and mail your order. Allow two weeks for delivery.

Benefits Description	You pay After the annual drug deductible...	
Note: The annual drug deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.		
Covered medications and supplies	You pay – Standard Option	You pay - High Option
<p>Each new enrollee will receive a description of our prescription drug program, a prescription drug identification card, a mail order form/patient profile and a preaddressed reply envelope.</p> <p>You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:</p> <ul style="list-style-type: none"> • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as Not covered. • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices • TPN (Total Parenteral Nutrition) that complies with Medicare guidelines. 	<p>Network Retail: \$4 generic</p>	<p>Network Retail: \$3 generic</p>
	<p>Network Retail Formulary Brand Name: The greater of \$30 or 20% of that Brand name.</p>	<p>Network Retail Formulary Brand Name: The greater of \$25 or 20% of that Brand name.</p>
	<p>Network Retail Non-Formulary Brand Name: The greater of \$40 or 20% of non-formulary brand name.</p>	<p>Network Retail Non-Formulary Brand Name: The greater of \$40 or 20% of non-formulary brand name.</p>
	<p>Non-Network Retail: 30% of the Plan allowance for a network pharmacy and any difference between our allowance and the billed amount.</p>	<p>Non-Network Retail: 20% of the Plan allowance for a network pharmacy and any difference between our allowance and the billed amount.</p>
	<p>Non-Network Retail Medicare: Same as Non-Network Retail for non-Medicare.</p>	<p>Non-Network Retail Medicare: Same as Non-Network Retail for non-Medicare.</p>

Covered medications and supplies - <i>continued</i>	You pay – Standard Option	You pay - High Option
<p>Each new enrollee will receive a description of our prescription drug program, a prescription drug identification card, a mail order form/patient profile and a preaddressed reply envelope.</p> <p>You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:</p> <ul style="list-style-type: none"> • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as Not covered. • Preauthorized growth hormone • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices • TPN (Total Parenteral Nutrition) that complies with Medicare guidelines. <p>Note: The Medicare level of benefits applies only when you are covered by Medicare Part B.</p>	Network Mail Order: \$8 generic	Network Mail Order: \$6 generic
	Network Mail Order Formulary Brand Name: The greater of \$30 or 20% of that Brand name.	Network Mail Order Formulary Brand Name: The greater of \$30 or 20% of that Brand name.
	Network Mail Order Non-Formulary Brand Name: The greater of \$40 or 20% of non-formulary brand name. (No deductible)	Network Mail Order Non-Formulary Brand Name: The greater of \$40 or 20% of non-formulary brand name. (No deductible)
	Network Mail Order Medicare: \$7 generic	Network Mail Order Medicare: \$7 generic
	Network Mail Order Medicare Formulary Brand Name: The greater of \$15 or 20% of that Brand name.	Network Mail Order Medicare Formulary Brand Name: The greater of \$15 or 20% of that Brand name.
	Network Mail Order Medicare Non-Formulary Brand Name: The greater of \$25 or 20% of non-formulary brand name. (No deductible)	Network Mail Order Medicare Non-Formulary Brand Name: The greater of \$25 or 20% of non-formulary brand name. (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Drugs to aid in smoking cessation other than those covered under the smoking cessation benefit.</i> • <i>Medical supplies such as dressings and antiseptics</i> 	<i>All Charges</i>	<i>All Charges</i>

Section 5(g) Special features

Special feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	<p>“Ask MAYO CLINIC” is the name of our program. The MAYO Clinics provide their registered nurses to discuss any of your health concerns, 24 hours a day, and 7 days a week. You may call 1-866-300-8717 and talk with a MAYO Clinic registered nurse who will discuss treatment options and answer your health questions.</p>
Tobacco Quit Phone Line	<p>You can call “Ask MAYO CLINIC” 24 hours a day, 7 days a week at 1-866-300-8717. Select option #2 for a specialized guidance counselor trained to help you quit smoking through personal counseling and a series of related publications.</p>
Complex Surgery	<p>On a case-by-case basis, we may decide to provide benefits under the special features provision for complex surgery. The MAYO Clinics operate three facilities (Minnesota, Florida, and Arizona) that specialize in providing effective and economical complex surgical care for a limited number of surgical services under certain circumstances. There surgical services could include hip/knee replacements, coronary bypass, heart valve replacement, or mastectomy. If the MAYO Clinics accept your particular case, you pay nothing for the hospital and surgical care they render. If the MAYO Clinics does not accept your case, you pay as described in Sections 5 (b) and 5 (c) of this brochure. This benefit includes transportation and lodging that we pre-approve. Call us at 1-800-544-7111 for details about seeking care at the MAYO Clinics.</p>
Centers of excellence	<p>See National Transplant Program under Organ/Tissue transplant in Section 5 (b). The MAYO Clinics operate three facilities (Minnesota, Florida, and Arizona) that specialize in providing effective and economical transplants for most organ transplants. If you receive a transplant, listed as covered under the Transplant Program, at the MAYO Clinics, you pay nothing for the hospital and surgical care they render. Call us at 1-800-544-7111 for details about seeking care at the MAYO Clinics.</p>
Dialysis Services	<p>You pay nothing for dialysis services and related drugs or medications provided by a GAMBRO or DAVITA dialysis center. If you get these services from a provider or facility other than GAMBRO or DAVITA, you pay all billed charges that are more than the Plan’s limit. The Plan’s limit for non-GAMBRO and non-DAVITA dialysis services and related drugs or medications is 150% of the Medicare allowance for those services. After the catastrophic provision limit is met, you pay nothing (<i>We will waive this limit for those ESRD Members living over 100 miles from contracted ESRD centers</i>).</p>

Special feature - <i>continued</i>	Description
<p>“Healthier Feds” - Asthma Hotline</p>	<p>“Ask <i>MAYO Clinic</i>” is the name of our program. The MAYO Clinics provide their registered nurses to discuss any of your health concerns, 24 hours a day, 7 days a week. You may call 1-866-300-8717 and talk with a MAYO Clinic registered nurse who will discuss treatment options and answer your health questions.</p>
<p>“Healthier Feds” - Arthritis Hotline</p>	<p>“Ask <i>MAYO Clinic</i>” is the name of our program. The MAYO Clinics provide their registered nurses to discuss any of your health concerns, 24 hours a day, 7 days a week. You may call 1-866-300-8717 and talk with a MAYO Clinic registered nurse who will discuss treatment options and answer your health questions.</p>
<p>“Healthier Feds” - Diabetes Hotline</p>	<p>“Ask <i>MAYO Clinic</i>” is the name of our program. The MAYO Clinics provide their registered nurses to discuss any of your health concerns, 24 hours a day, 7 days a week. You may call 1-866-300-8717 and talk with a MAYO Clinic registered nurse who will discuss treatment options and answer your health questions.</p>

Special Features - <i>continued</i>	Description
<p>PBP/MAYO “Lifestyle Coaching” & Healthier FEDS Benefits”</p> <p>PBP/MAYO Personal Weight Loss MAYO RN Nurse Advisor</p> <p>PBP/MAYO Stress Reduction Techniques by Lifestyle RN MAYO Nurse Coach</p> <p>PBP/MAYO Stop Smoking Personal RN MAYO Nurse Lifestyle Coach</p> <p>PBP/MAYO CLINIC Personal Exercise Trainer MAYO RN Lifestyle Coach</p>	<p>These are “Special Features” of PBP designed to complement OPM’s “<i>Healthier FEDS</i>” program. The benefits above are available to all members and dependents at NO Cost. Your doctor’s written permission is required to ensure your own well being and safety PRIOR to any new exercise program. Please have you doctor FAX her or his permission on official letterhead to PBP FAX 1-703-683-5411. You will then promptly receive PBP’s special instructions and guidance regarding these benefits. Generally, each personalized program (<i>designed specifically for you</i>) lasts 6 months. MAYO recommends completing one program before starting the next program.</p>

Section 5(h) Dental benefits

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is a \$30 per person annual dental deductible under High Option. There is no dental deductible under Standard Option.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: We cover hospitalization for dental procedures only when the patient has a non-dental physical impairment which makes hospitalization necessary to safeguard the patient's health. See Section 5 (c) for inpatient hospital benefits.

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Accidental injury benefit	You pay - Standard Option	You pay - High Option
<ul style="list-style-type: none"> • 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. • Note: Injury to the teeth from chewing or biting is not considered an accidental injury for purposes of this provision. 	<p>Any amount over the High Option Schedule of allowances.</p>	<p>Any amount over the High Option Schedule of allowances.</p>

Dental benefits

- We provide dental benefits for services listed in the following Schedule of dental allowances:
- Under Standard Option, we cover charges up to the applicable allowance shown in the Schedule of dental allowances. There is no calendar year maximum.
- Under High Option, after the \$30 yearly dental deductible, we cover charges up to a percentage of the applicable allowance shown in the Schedule of dental allowances. This percentage depends upon the number of calendar years the member has been continuously enrolled under the High Option of this Plan, as follows: first calendar year, **50%** of scheduled allowance; second calendar year, **75%** of scheduled allowance, thereafter, **100%** of scheduled allowance.
- Under High Option the maximum benefit payable for any calendar year is \$800 per person, \$2,000 per family. Only scheduled allowances shown in the Schedule of dental allowances may be applied toward the dental deductible or the maximum payable.
- The following Schedule of dental allowances is a complete list of covered dental services available.
- **Note:** We pay actual charges up to the scheduled allowances shown in this booklet.
- Delta Dental administers all of our Dental benefits. There is a NON-FEHB Dental Supplement available on a voluntary basis for which the member pays. See the NON-FEHBP portion of this booklet. For information, call 1-800-352-1974.

Dental benefits	We pay (scheduled allowance)		You pay
	Service	Standard Option	
Basic services			
Diagnostic			
Periodic oral evaluation (routine exams limited to two per year)	\$6.50	\$6.50	* All charges in excess of the scheduled amounts listed to the left
Limited oral evaluation – problem focused	\$6.50	\$6.50	*
Comprehensive oral evaluation	\$9.00	\$9.00	*
Detailed and extensive oral evaluation- problem focused, by report	N/A	\$11.00	*
Intraoral, complete series including bite wings (limited to one every three years)	\$15.00	\$23.00	*
Intraoral periapical first film	\$1.00	\$3.50	*
Intraoral, periapical each additional film	\$1.00	\$1.00	*
Intraoral, occlusal film	\$7.50	\$7.50	*
Extraoral, first film	N/A	\$7.00	*
Extraoral, each additional film	N/A	\$7.00	*
Bitewing, single film	\$3.00	\$3.50	*
Bitewings, two films	\$4.00	\$6.50	*
Bitewings, four films (bitewings limited to two series per year)	\$6.50	\$9.50	*
Panoramic film (considered a complete series)	\$15.00	\$19.00	*
Pulp vitality	N/A	\$7.00	*
Diagnostic casts	N/A	\$15.50	*
Preventive			
Prophylaxis, adult (age 14 or over) (prophylaxes or cleanings are limited to two per year)	\$10.50	\$14.50	*
Prophylaxis, child (under age 14) (prophylaxes or cleanings are limited to two per year)	\$10.50	\$10.50	*
Topical application of fluoride, including prophylaxis	\$16.00	\$17.00	*
Topical application of fluoride, prophylaxis not included (application of fluoride, limited to one per year and to children under age 14)	\$5.50	\$6.50	*
Space maintainer, fixed, unilateral	N/A	\$77.50	*
Space maintainer, fixed, bilateral	N/A	\$77.50	*
Space maintainer, removable, unilateral	N/A	\$113.50	*
Space maintainer, removable, bilateral	N/A	\$113.50	*
Recementation of space maintainer (space maintainer are passive appliance, schedule limit includes all adjustments)	N/A	\$10.00	*

Restorative	Standard Option	High Option	You pay
Note: Multiple restorations on one surface will be considered as a single restoration.			
Amalgam, one surface, primary	\$11.50	\$13.50	*
Amalgam, two surfaces, primary	\$16.50	\$19.50	*
Amalgam, three surfaces, primary	\$22.00	\$25.00	*
Amalgam, one surface, permanent	\$11.50	\$14.50	*
Amalgam, two surfaces, permanent	\$18.00	\$22.00	*
Amalgam, three surfaces, permanent	\$22.00	\$29.50	*
Silicate cement	\$16.50	\$18.00	*
Resin, one surface	\$11.50	\$17.00	*
Resin, two surfaces	\$18.00	\$24.00	*
Resin, three surfaces	\$22.00	\$29.50	*
Pin retention, per tooth in addition to restoration	N/A	\$10.50	*
Endodontics			
Pulp cap, direct	N/A	\$9.50	*
Pulp cap, indirect	N/A	\$9.50	*
Therapeutic pulpotomy	N/A	\$17.50	*
Root canal, one	N/A	\$108.00	*
Root canal, two	N/A	\$131.00	*
Root canal, three or more	N/A	\$178.50	*
Apexification/recalcification-initial visit	N/A	\$7.00	*
Apicoectomy/periradicular surgery-anterior	N/A	\$113.00	*
Periodontics			
Gingivectomy or gingivoplasty, per quadrant	N/A	\$86.00	*
Gingivectomy or gingivoplasty, per tooth	N/A	\$22.00	*
Gingival curettage, surgical, per quadrant, by report	N/A	\$12.00	*
Gingival flap procedure including root planning, per quadrant	N/A	\$33.50	*
Clinical crown lengthening-hard tissue	N/A	\$90.00	*
Osseous surgery (including flap entry and closure) per quadrant	N/A	\$194.00	*
Bone replacement graft-first site in quadrant	N/A	\$84.00	*
Free soft tissue procedure (including donor site surgery)	N/A	\$142.00	*
Provisional splinting, intracoronal	N/A	\$33.50	*
Provisional splinting, extracoronal	N/A	\$35.50	*
Periodontal scaling and root planing, per quadrant	N/A	\$15.00	*
Periodontal maintenance procedure (following active therapy)	N/A	\$19.50	*
Prostodontics (removable) repairs			
Repair broken complete denture base	N/A	\$26.00	*
Replace missing or broken teeth, complete denture (each tooth)	N/A	\$5.00	*
Repair resin denture base	N/A	\$25.00	*
Repair cast framework	N/A	\$34.00	*
Repair or replace broken clasp	N/A	\$20.00	*

Prostodontics (removable) – Continued on next page

Prosthodontics (removable) repairs -continued	Standard Option	High Option	You Pay
Replace broken teeth, per tooth	N/A	\$5.00	*
Add tooth to existing partial denture	N/A	\$11.00	*
Add clasp to existing partial denture	N/A	\$24.00	*
Oral surgery (includes local anesthesia and routine postoperative care)			
Extraction, single teeth	\$12.50	\$17.00	*
Extraction, each additional tooth	\$7.50	\$14.50	*
Root removal, exposed roots	N/A	\$18.00	*
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$19.00	\$24.00	*
Surgical removal of residual tooth roots (cutting procedure)	N/A	\$28.50	*
Surgical exposure of impacted or unerupted tooth to aid eruption	N/A	\$46.50	*
Alveoloplasty in conjunction with extractions per quadrant	N/A	\$30.50	*
Alveoloplasty not in conjunction with extractions per quadrant	N/A	\$49.50	*
Removal of odontogenic cyst or tumor, lesion diameter up 1.25 cm	N/A	\$42.00	*
Removal of odontogenic cyst or tumor, lesion diameter over 1.25 cm	N/A	\$94.50	*
Incision and drainage of abscess, intraoral soft tissue	N/A	\$24.50	*
Incision and drainage of abscess, extraoral soft tissue	N/A	\$24.50	*
Excision of hyperplastic tissue, per arch	N/A	\$67.00	*
Excision of pericoronal gingiva	N/A	\$28.50	*
Adjunctive general services			
General anesthesia	N/A	\$45.00	*
Analgesia	N/A	\$9.00	*
Intravenous sedation	N/A	\$43.00	*
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	N/A	\$18.00	*
Office visit for observation (during regularly scheduled hours)	N/A	\$6.50	*
Office visit, after regularly scheduled hours	N/A	\$8.00	*
Occlusion analysis, mounted case	N/A	\$17.50	*
Occlusal adjustment, limited	N/A	\$25.00	*
Occlusal adjustment, complete	N/A	\$110.00	*
Major services			
Restorative			
Gold foil, one surface	N/A	\$24.50	*
Gold foil, two surfaces	N/A	\$53.50	*
Gold foil, three surfaces	N/A	\$74.50	*

Restorative – Continued on next page

Restorative – continued	Standard Option	High Option	You Pay
Inlay, metallic, one surface	N/A	\$40.00	*
Inlay, metallic, two surfaces	N/A	\$92.50	*
Inlay, metallic, three or more surfaces	N/A	\$117.50	*
Inlay, porcelain/ceramic, one surface	N/A	\$24.50	*
Inlay, porcelain/ceramic, two surfaces	N/A	\$45.00	*
Inlay, porcelain/ceramic, three or more surfaces	N/A	\$69.00	*
Crown, resin (laboratory)	N/A	\$73.50	*
Crown, resin with high noble metal	N/A	\$198.50	*
Crown, resin with predominantly base metal	N/A	\$167.00	*
Crown, resin with noble metal	N/A	\$182.50	*
Crown, porcelain/ceramic substrate	N/A	\$184.00	*
Crown, porcelain fused to high noble metal	N/A	\$215.50	*
Crown, porcelain fused to predominantly base metal	N/A	\$184.00	*
Crown, porcelain fused to noble metal	N/A	\$199.50	*
Crown, full cast high noble metal	N/A	\$203.50	*
Crown, full cast predominantly base metal	N/A	\$172.00	*
Crown, full cast noble metal	N/A	\$188.00	*
Crown, ¾ cast metallic	N/A	\$198.50	*
Recent inlay	N/A	\$11.50	*
Recent crown	N/A	\$11.50	*
Prefabricated stainless steel crown primary or permanent tooth	N/A	\$40.00	*
Prefabricated resin crown	N/A	\$40.00	*
Sedative filling	N/A	\$8.00	*
Core buildup including any pins	N/A	\$2.00	*
Cast post and core in addition to crown	N/A	\$56.50	*
Prefabricated post and core in addition to crown	N/A	\$32.00	*
Temporary crown (fractured tooth)	N/A	\$40.00	*
Prostodontics (removable)			
Complete upper or lower denture	N/A	\$242.50	*
Immediate upper or lower denture	N/A	\$275.00	*
Maxillary partial denture-resin (including any conventional clasps, rest and teeth)	N/A	\$237.50	*
Mandibles partial denture-resin base (including any conventional clasps, rest and teeth)	N/A	\$237.50	*
Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps and teeth)	N/A	\$271.00	*
Mandibular partial denture-cast metal framework with resin denture bases (including any conventional clasps, rest and teeth)	N/A	\$271.00	*
Removable unilateral partial denture-one piece cast metal (including clasps and teeth)	N/A	\$157.50	*

Prostodontics (removable) – Continued on next page

Prosthodontics (removable) – <i>continued</i>	Standard Option	High Option	You pay
Adjust complete upper or lower denture	N/A	\$17.00	*
Adjust partial upper or lower denture	N/A	\$17.00	*
Rebase complete denture	N/A	\$94.50	*
Rebase partial denture	N/A	\$71.00	*
Reline complete denture (chairside)	N/A	\$56.50	*
Reline partial denture (chairside)	N/A	\$43.00	*
Reline complete denture (laboratory)	N/A	\$76.00	*
Reline partial denture (laboratory)	N/A	\$65.00	*
Interim complete denture	N/A	\$115.50	*
Interim partial denture	N/A	\$65.00	*
Tissue conditioning per denture unit	N/A	\$20.00	*
Overdenture, complete, by report	N/A	\$350.00	*
Overdenture, partial, by report	N/A	\$280.00	*
Precision attachment, by report	N/A	\$98.00	*
Prosthodontics (fixed)			
Pontic, cast high noble metal	N/A	\$204.00	*
Pontic, cast predominantly base metal	N/A	\$172.00	*
Pontic, cast noble metal	N/A	\$188.00	*
Pontic, porcelain fused to high noble metal	N/A	\$215.50	*
Pontic, porcelain fused to predominantly base metal	N/A	\$184.00	*
Pontic, porcelain fused to noble metal	N/A	\$199.50	*
Pontic, resin with high noble metal	N/A	\$222.00	*
Pontic, resin with predominantly base metal	N/A	\$175.00	*
Pontic, resin with noble metal	N/A	\$197.00	*
Inlay, metallic two surfaces	N/A	\$92.50	*
Inlay, metallic three or more surfaces	N/A	\$117.50	*
Retainer-Cast metal for resin bonded fixed prosthetics	N/A	\$34.00	*
Crown, resin with high noble metal	N/A	\$215.50	*
Crown, resin with predominantly base metal	N/A	\$184.00	*
Crown, resin with noble metal	N/A	\$199.50	*
Crown, porcelain fused to high noble metal	N/A	\$234.00	*
Crown, porcelain fused to predominantly to base metal	N/A	\$185.00	*
Crown, porcelain fused to noble metal	N/A	\$205.00	*
Crown, ¾ cast high noble metal	N/A	\$198.50	*
Crown, full cast high noble metal	N/A	\$209.00	*
Crown, full cast predominantly base metal	N/A	\$187.00	*
Crown, full cast noble metal	N/A	\$185.00	*
Recement fixed partial denture	N/A	\$21.00	*
Stress breaker	N/A	\$56.50	*
Precision attachment	N/A	\$92.50	*
Cast post and core in addition to fixed partial denture retainer	N/A	\$66.00	*

Prosthodontics (fixed) – Continued on next page

Prosthodontics (fixed) - continued	Standard Option	High Option	You pay
Cast post as part of fixed partial denture retainer	N/A	\$51.00	*
Prefabricated post and core in addition to fixed partial denture retainer	N/A	\$37.00	*
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services and supplies furnished by other than a licensed dentist, except for a prophylaxis (cleaning) which may be performed by a licensed dental hygienist working under the supervision of a dentist or an accredited school of dentistry</i> • <i>Dental services and supplies for which other benefits are payable</i> • <i>Replacement of bridges, dentures or appliances within five years of coverage of previous placement by this Plan</i> • <i>Fluorides for home use</i> • <i>Dental implants</i> • <i>Any dental service or supply for cosmetic purposes</i> • <i>Training in preventive care, oral hygiene or dietary practices</i> • <i>Orthodontic treatment</i> 	N/A	N/A	All charges

Note: For questions related to Dental benefits, call Delta Dental Plan of Virginia at **1-800-352-1974**.

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

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

\$1,400 Annual Maximum Dental Benefit – Administered by Delta Dental

The **PBP Health Plan (PBP)** and its sponsor, the National **League** of Postmasters are pleased to offer two (2) new dental plans, which are administered by Delta Dental. The first dental plan is called “***PBP’s USA First***” and is for persons who are current PBP members or who are joining PBP this year. PBP’s Plan offers one of the widest, most comprehensive set of dental benefits because it offers our current PBP fixed schedule of benefits (shown in this booklet) with this option to purchase a higher level of coverage. **The second plan is called the “*League Only*”** program for persons who belong to the LEAGUE, but not the PBP Health plan. Both plans are voluntary, supplemental and offer \$1,400 **maximum** in covered dental services on a per person per calendar year basis. A separate \$850 **lifetime** orthodontic maximum on a per person basis is also provided. The following are some of the benefits of this dental plan:

NON-FEHB Dental Benefit	In-Network	Out-of Network
Exams, Cleanings, X-rays	100 %	70 %
Simple restorative, Denture repair, Sealants	80%	60 %
Prosthetics, Crowns and Orthodontics	50 %	50 %

For more information about these dental plans or to request an application, call or write to ASI, P.O. Box 2510, Rockville, MD 20847 or 1-877-598-7089. DeltaPreferred Option USA * is underwritten by Delta Dental Plan of Virginia, 4818 Starkey Road SW, Roanoke, Virginia 24014 or 1-800-352-1974.

Special LIFE INSURANCE Gives ALL PBP Members \$12,000 AD&D life insurance at NO Cost. You also have a qualified right to buy Up to \$500,000 Group Term Life

There is NO COST to you for the \$12,000 in Accidental Death Life Insurance for yourself, if you join the PBP Health Plan. Acceptance is guaranteed. There are no medical forms to be filled out. You get this \$12,000 Accidental Death Coverage just for being a PBP Health Plan member. **This plan is sponsored by the National League of Postmasters, and offers the following:**

Voluntary Optional or Supplement Regular TERM LIFE Insurance

- Secure up to \$500,000 of Term Life Protection
- Double benefit for workplace accidental deaths (including deaths while commuting to and from work)
- Guaranteed conversion to cash-value Whole Life Plan at any time prior to your 70th birthday
- Premiums waived during strike or lockout

TERM TO – 100 (Senior Life Plan)

- Secure between \$5,000 - \$25,000 of Term Life Protection
- Level Term insurance to age 100
- Guaranteed payout at age 100
- Rates locked in at time of application and do not increase with age
- Living benefit and accidental death features included
- Provides \$10,000 of workplace accidental death insurance and \$2,000 worldwide 24 hour coverage at no-cost to the member, acceptance is guaranteed
- Secure up to \$350,000 of around-the-clock accident protection
- Family Plan includes additional coverage for common carrier, workplace, and motor vehicle accidental deaths

This insurance is underwritten by the Union Labor Life Insurance Company (ULLICO). For additional information regarding this life insurance, you may write to: ULLICO, Administrative Offices, Fort Worth, Texas, 76185.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as 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 that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- 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;
- Charges that would not be made if covered individual had no health insurance coverage;
- Services furnished by immediate relatives or household members, such as a spouse, parent, child, brother, or sister, by blood, marriage or adoption;
- Services furnished or billed by a non-covered facility, except that medically necessary prescription drugs are covered;
- Services not specifically listed as covered;
- Services provided in connection with a non-covered service;
- 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, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges neither you nor we have a legal obligation to pay, such as excess charges for annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 17), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge see page 17), or State premium taxes however applied;
- Routine preventive care, immunizations and all related expenses except as provided herein;
- Treatment for weight control or reduction (except morbid obesity);
- Social, recreational and educational services or training not specifically listed as covered;
- Therapy, other than speech therapy, for developmental delays, learning disabilities, stuttering, tongue thrusting or deviate swallowing;
- Treatment of temporomandibular joint disorder;
- Services rendered by Christian Scientist providers (including sanitariums);
- Services rendered by massage therapists, rollers, myotherapists, and trager clinics;
- Services rendered by hypnotherapists, neuromuscular therapists and naturopaths;
- Hospital benefits for admissions required for surgical procedures excluded by us;

General exclusions - *continued*

- Interest, completion of claim forms, or similar administrative charges made by providers;
- Travel, transportation, convalescent care or rest cures;
- Services and supplies for cosmetic purposes such as Rogaine or wigs (*except for Cancer Victims*)
- Electronic bone-growth stimulators or similar devices;
- Ventilation and respiratory therapy that are NOT billed as a part of skilled nursing;
- Leg presses or similar devices.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 1-800-544-7111, or at our Web site at www.pbp.org.

In most cases, providers and facilities file claims for you. Your physician must file on the form **HCFA-1500**, Health Insurance Claim Form. Your facility will file on the **UB-92 form**. For claims questions and assistance, call us at 1-800-544-7111.

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

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

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

In addition:

- You must send a copy of the explanation of benefits (EOB) from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- 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.
- Claims for prescription drugs and supplies that are not ordered through the Mail Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- We will provide translation and currency conversion services for claims for overseas (foreign) services.

Records

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

Deadline for filing your claim

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

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send a completed Overseas Claim Form and the itemized bills to: PBP Health Plan Attn: Claims Review Dept. 1019 North Royal Street. Alexandria, VA 22314. Obtain Overseas Claim Forms from: PBP Health Plan Attn: Claims Review Dept. 1019 North Royal Street. Alexandria, VA 22314. Send any written inquiries concerning the processing of overseas claims to this address.

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: PBP Health Plan, 1019 North Royal Street Alexandria, VA 22314 andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p>

The disputed claims process (*continued*)

Send OPM the following information:

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

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

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

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

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

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

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

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-544-7111 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays 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 payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If our benefits are subject to visit limits, we may apply those visit limits to our secondary payments.

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

• 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 to set up an appointment to apply. If you do not apply for one or both 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 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 private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800-544-7111 or see our Web site at www.pbp.org

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

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive the calendar year deductible and coinsurance.
- Surgical and anesthesia services provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we waive the calendar year deductible and the coinsurance.
- Services provided by a hospital or other facility, and ambulance services. If you are enrolled in Medicare Part A, we waive the per admission copayment and the coinsurance. If you are enrolled in Medicare Part B, we waive the calendar year deductible and the coinsurance for covered ambulance services.
- Emergency services/Accidents. If you are enrolled in Medicare Part B, we waive the coinsurance and copayment for covered emergency room charges. If you are enrolled in Medicare Part B, we waive the calendar year deductible and the coinsurance for covered ambulance services.
- Mental health and substance abuse. If you are enrolled in Medicare Part A, we waive the per admission copayment and the mental health and substance abuse coinsurance. If you are enrolled in Medicare Part B, we waive the mental health and substance abuse deductible and coinsurance.

In cases where we cover a service that is not covered by Medicare, we are the primary payer. In these cases, we do not waive any catastrophic protection out-of-pocket costs.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) 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 #1 above	✓	
4) 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	✓	
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and... <ul style="list-style-type: none"> • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period) 		✓
<ul style="list-style-type: none"> • 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... <ul style="list-style-type: none"> • This Plan was the primary payer before eligibility due to ESRD 		✓ for 30-month coordination period
<ul style="list-style-type: none"> • Medicare was the primary payer before eligibility due to ESRD 	✓	
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

- **Medicare Advantage**

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) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) 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 (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a 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 Medicare Advantage plan's service area.

- **Private Contract with your physician**

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

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.

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally 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 or any covered member of your family suffer injuries in an accident, or become ill, because of the actions of another person, and you thereafter receive compensation, either from that person or from your own or other insurance, for the injuries or illness, you will be required to reimburse the Plan for any services and supplies the Plan paid for out of the compensation you receive. This is known as the Plan's right of reimbursement, and is also sometimes referred to as subrogation.

You will have this obligation to reimburse the Plan even if the compensation you receive is not sufficient to compensate you fully for all of the damages which resulted from the accident or illness. In other words, the Plan is entitled to be reimbursed for all expenditures it has made on your behalf even if you are not "made whole" for all of your damages by the compensation you receive.

The Plan's right to reimbursement is also not subject to reduction for attorney's fees under the "common fund" doctrine without the Plan's written consent. The Plan enforces this right of reimbursement by asserting a lien against any and all compensation you receive, whether by court order or out-of-court settlement. You must cooperate with the Plan in its enforcement of this right of reimbursement by telling the Plan whenever you or a covered member of your family has filed a claim for compensation resulting from an accident or illness. You must also accept the Plan's lien for the full amount of the benefits it has paid; you must agree to assign any proceeds from third party claims or your own insurance to the Plan when asked to do so; and you must sign a Reimbursement Agreement for this purpose when asked by the Plan to do so.

We will not pay benefits until this agreement is signed. The Plan's right to full reimbursement applies even if the Plan has paid benefits before we know of the accident or illness, and before we have asked you to sign a Reimbursement Agreement. Unless the Plan agrees in writing to accept less than 100% of the Plan's lien amount, the Plan is entitled to be reimbursed for all the benefits it has paid on account of the accident or illness. If you would like more information about the subrogation process and how it works, please call the Plan's Third Party Recovery Services unit at 703-683-1664 or FAX information to 703-683-5411 at PBP.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 13.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Services we provide benefits for, as described in this brochure.
Custodial care	<p>Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:</p> <ol style="list-style-type: none">(1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;(2) homemaking, such as preparing meals or special diets;(3) moving the patient;(4) acting as companion or sitter;(5) supervising medication that can usually be self administered; or(6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and and 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 13.
Experimental or investigational services	<p>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.</p> <p>A medical treatment or procedure, or a drug , device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.</p> <p>Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.</p>

Note: We use a formal procedure to determine if a service is experimental or investigational. We review claims with no procedure codes or experimental procedure codes. Physicians and medical specialists review complex claims and recommend whether we should consider the procedure to be experimental or investigational. We make the final decision.

A service or supply may be experimental or investigational if a:

- Product is not FDA approved,
- Service or treatment is still in some stage of trials,
- Service or treatment is not normally used to treat your condition, or
- Provider requires that you sign a special release prior to receiving the care.

Enrollees who have a question about a specific service or supply may call us at 800-544-7111

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.

Home health care agency

An agency or organization that provides a program of home health care that meets all the following requirements: (1) it is certified by the patient's doctor as an appropriate provider of home health services; (2) it has a full-time administrator; (3) it maintains written records of services provided to the patient; and (4) its staff includes at least one registered nurse(R.N.).

Incurred date

The date services and supplies are received. The applicable benefits are those in effect on this date. The incurred date for major dental care expenses that involve preparatory services is the date the inlay, crown, bridge or denture is seated, placed or installed in the patient's mouth.

Medical necessity

Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that we determine;

- 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 or dentally necessary.

Mental conditions/substance abuse

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

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:

We refer to national databases such as those provided by Ingenix, Interqual and Milliman & Robertson to determine the prevailing health care charges in a given geographic area. We use the 70th percentile of those charges as the Plan allowance for a given covered service in a geographic area. In some cases such as Dental benefits, the Plan Allowance is printed in this brochure. Charges subject to the Plan Allowance include, but are not limited to, charges for all surgery, anesthesia, medical care and mental health care.

We also use special industry or federal guidelines or consult with medical specialists to establish an allowance based on unusual cases or complex care. When we negotiate a discounted fee on an individual claim, that fee is the Plan Allowance. The fees that are negotiated with network providers as part of their network contract are considered the Plan Allowances. If you use a network provider, your cost is limited to the cost sharing provisions listed in this brochure’s benefit charts. If you use a non-network provider, you are also responsible for charges in excess of the Plan allowance.

Remission (hospice care)

A remission is the halt or actual reduction in the progression of illness resulting in discharge from a hospice care program with no further expenses incurred. A readmission within three months of a prior discharge is considered as part of the same period of care. A new period begins three months after a prior discharge with maximum benefits available.

Sound natural tooth

A natural tooth that is whole or properly restored, without impairing periodontal or other conditions and not in need of the treatment rendered or proposed for any reason other than accidental injury.

Surgery

A “surgical procedure” means cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, endoscopy or injecting sclerosing solution.

Us/We

Us and We refer to PBP Health Plan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment as well as:

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

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

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

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

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

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

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

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

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

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the 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 2005 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 2004 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.

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

- **Spouse equity coverage**

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

- **Temporary Continuation of Coverage (TCC)**

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

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12. Two Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of two Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

Online: visit www.FSAFEDS.com and click on **Enroll**.

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

What is SHPS?

SHPS is a Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for the enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claims for eligible expenses.

The [FSAFEDS Calculator](http://www.FSAFEDS.com) at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 15 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under the High Option of this Plan, typical out-of-pocket expenses include: 1) Member share of premium; 2) Rx copayments; 3) Dental deductibles.

Under the Standard Option of this Plan, typical out-of-pocket expenses include: 1) Member share of premium; 2) Rx copayments; 3) Dental deductibles.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at www.irs.gov/pub/irs-pdf/p502.pdf. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed, please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

The DCFSA generally allows many families to save more than they would with the Federal Tax Credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection** Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for the Standard Option of PBP Health Plan – 2005

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the \$250 (\$600 non-PPO) calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

STANDARD OPTION Benefits	You pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office..... 	PPO: 9%* Non-PPO: 30%*	20-21
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient..... • Outpatient..... 	PPO: 10% Non-PPO: 30% PPO: 9% Non-PPO: 30%	42-43 44
Emergency benefits <ul style="list-style-type: none"> • Accidental injury • Medical emergency..... 	PPO: \$0, PPO: charges over our allowance PPO: \$50 then 9%, non-PPO: \$50 then 30%	47-48 48
Mental health and substance abuse treatment.....	PPO: Same as medical Non-PPO: Reduced benefits	49-51
Prescription drugs.....		
<ul style="list-style-type: none"> • Network retail 	\$4 generic, 20% Plan allowance or \$30 formulary, or 20% Plan allowance or \$40 non-formulary	53
<ul style="list-style-type: none"> • Non-network retail 	30% of Plan allowance and amounts over our allowance	53
<ul style="list-style-type: none"> • Mail order 	\$8 generic, 20% Plan allowance or \$30 formulary, or 20% Plan allowance or \$40 non-formulary	54
<ul style="list-style-type: none"> • Mail order with Medicare 	\$7 generic, 20% Plan allowance or \$15 formulary, or 20% Plan allowance or \$25 non-formulary	54
Special features: Flexible benefits option, 24-hour nurse line, Tobacco quit phone line, Complex surgery, Centers of excellence, Dialysis services	Nothing	55
Dental Care	Charges over our fee schedule	58-64
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$3,500 (\$5,000 non-PPO) per person or \$4,000 (\$5,500 non-PPO) per family per year Some costs do not count toward this protection	14-15

Summary of benefits for the High Option of PBP Health Plan – 2005

- **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 \$200 (\$500 non-PPO) calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	PPO: 10%* Non-PPO: 25%*	20-21
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient..... • Outpatient..... 	PPO: 10% Non-PPO: 25% PPO: 10% Non-PPO: 25%	44-45 46
Emergency benefits <ul style="list-style-type: none"> • Accidental injury • Medical emergency 	PPO: \$0, PPO: charges over our allowance PPO: \$50 then 10%, non-PPO: \$50 then 25%	49-50 50
Mental health and substance abuse treatment.....	In-Network: Same as medical Out-of-Network: Reduced benefits	51-53
Prescription drugs.....		
<ul style="list-style-type: none"> • Network retail 	\$3 generic, 20% Plan allowance or \$25 formulary, or 20% Plan allowance or \$40 non-formulary	54
<ul style="list-style-type: none"> • Non-network retail 	20% of Plan allowance and amounts over our allowance	55
<ul style="list-style-type: none"> • Mail order 	\$6 generic, 20% Plan allowance or \$25 formulary, or 20% Plan allowance or \$40 non-formulary	55
<ul style="list-style-type: none"> • Mail order with Medicare 	\$5 generic, 20% Plan allowance or \$12 formulary, or 20% Plan allowance or \$25 non-formulary	55
Dental care	Charges over our fee schedule	60-66
Special features: Flexible benefits option, 24-hour nurse line, Tobacco quit phone line, Complex surgery, Centers of excellence, Dialysis services	Nothing	57-59
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$3,000 (\$3,500 non-PPO) per person or \$3,500 (\$4,000 non-PPO) per family per year Some costs do not count toward this protection	15-16

2005 Rate Information for PBP HEALTH PLAN

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

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

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

		Non-Postal Premium				Postal Premium	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	361	\$131.08	\$173.38	\$284.01	\$375.65	\$154.74	\$149.72
High Option Self and Family	362	\$298.23	\$358.64	\$646.17	\$777.05	\$352.08	\$304.79
Standard Option Self Only	364	\$131.08	\$73.36	\$284.01	\$158.94	\$154.74	\$ 49.70
Standard Option Self and Family	365	\$298.23	\$164.86	\$646.17	\$357.19	\$352.08	\$111.01