

MHBP Consumer Option 2012 Benefit Summary

This is a summary of the MHBP Consumer Option. DO NOT RELY ON THIS CHART ALONE. All benefits are fully described in the 2012 official Plan Brochure (RI 71-016).

Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA, only applies if you are not eligible for a HSA)

Annual Contribution	HSA	HRA
MHBP: (up to)	\$845 (Self Only); \$1,690 (Self & Family)	\$845 (Self Only); \$1,690 (Self & Family)
Member, <i>Optional</i> : (up to)	\$2,255 (Self Only); \$4,560 (Self & Family)	You cannot contribute to an HRA
Calendar Year Deductible	Self Only	Self and Family
Deductible	\$2,000	\$4,000
PREVENTIVE CARE/WELLNESS (calendar year deductible does not apply to PPO preventive care)	You Pay	
	PPO Benefits	Non-PPO Benefits
Adult annual physical exam (office visit)	Nothing	All charges
Adult routine screenings and immunizations including cholesterol screenings, mammograms, Pap and HPV tests, PSA tests, bone density screening, urinalysis, colon cancer screenings and more.	Nothing	All charges
Well-child care (routine office visits, immunizations and certain screenings)	Nothing	All charges
QuitPower® tobacco cessation program – up to two quit attempts per year, with four counseling sessions per attempt and over-the-counter (OTC) drugs approved by the FDA to treat tobacco dependence.	Nothing	Nothing
Physician-prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing	All charges
TRADITIONAL MEDICAL COVERAGE (calendar year deductible applies to all benefits)	You Pay	
	PPO Benefits	Non-PPO Benefits
Physician Care		
Doctor's office visits (primary care physicians and specialists)	\$15 copay	40% of the Plan's allowance and any difference between our allowance and the billed amount
Convenient Care Center visits (such as MinuteClinic® or Take Care Clinic SM)	\$10 copay	
Maternity	Nothing	
Surgery – Inpatient	Nothing	
Surgery – Outpatient (at a hospital or ambulatory surgical center)	Nothing	
Hospital/Facility Care		
Inpatient hospital (room and board and ancillary services, precertification required)	\$75 per day, up to \$750 for hospital ancillary services	40% of the Plan's allowance and any difference between our allowance and the billed amount
Inpatient maternity (no precertification required)		
Outpatient hospital or ambulatory surgical facility – Surgical	\$150 copay per occurrence	
Outpatient hospital or ambulatory surgical facility – Non-surgical	\$25 copay per visit	
Emergency Services		
Emergency room visits	\$50 copay (waived if admitted to the hospital)	\$50 copay and any difference between our allowance and the billed amount (copay waived if admitted to the hospital)
Urgent Care Center visits	\$15 copay	40% of the Plan's allowance and any difference between our allowance and the billed amount
Ambulance	Nothing	
Lab, X-ray and Other Diagnostics		
Non-routine Lab, X-ray and other diagnostic tests (Preauthorization is required for specialized imaging procedures such as CT/CAT scans, MRI and PET)	\$15 copay	40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program	You pay nothing for covered lab tests with the Lab Savings Program with Quest Diagnostics®	
Alternative Treatments		
Chiropractic and Acupuncture	\$15 copay per visit for up to 26 visits per person per calendar year, includes alternative, chiropractic and rehabilitative therapies combined; all charges after 26 visits.	40% of the Plan's allowance and any difference between our allowance and the billed amount for up to 26 visits; all charges after 26 visits.
Catastrophic Protection Out-of-Pocket Maximum		
You pay nothing for the rest of the calendar year after your out-of-pocket expenses for covered medical services totals this amount (includes your annual deductible and the copayments and non-PPO coinsurance, but does not include amounts in excess of the Plan's allowance or benefit maximums and certain other expenses).	\$5,000 Self Only (PPO providers) \$10,000 Self & Family (PPO providers)	\$7,500 Self Only (Non-PPO providers) \$15,000 Self & Family (Non-PPO providers)
PRESCRIPTION DRUG COVERAGE (calendar year deductible applies to prescription drug benefits)	You pay	
	Network Pharmacy and Electronic Claims	Non-Network Pharmacy and Paper Claims
Network Retail Pharmacy (up to a 30-day supply)		
Generic	\$10 copay	All charges
Preferred Brand*	\$25 copay	
Non-Preferred Brand*	\$40 copay	
Mail Order Drug Program (up to a 90-day supply)		
Generic	\$20 copay	All charges
Preferred Brand*	\$50 copay	
Non-Preferred Brand*	\$80 copay	

*You will pay the copayment amount and the difference in cost between the generic and brand name drugs when a generic is available, unless preauthorized.

MHBP Consumer Option 2012 Rates	Federal Biweekly	Postal		Annuitants Monthly
		Category 1 Biweekly	Category 2 Biweekly	
Self Only – 481	\$53.34	\$35.20	\$33.07	\$115.57
Self and Family – 482	\$120.86	\$79.77	\$74.93	\$261.86



These rates do not apply to all enrollees. If you are in a special enrollment category, please refer to your Guide to Federal Benefits or contact the agency that maintains your health benefits enrollment.

This is a summary of the Mail Handlers Benefit Plan Consumer Option. Before making a final decision, please read the 2012 official Plan brochure (RI 71-016). All benefits are subject to the definitions, limitations and exclusions set forth in the 2012 official Plan brochure (RI 71-016). A single annual \$42 associate membership fee makes all MHBP plans available to you.

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