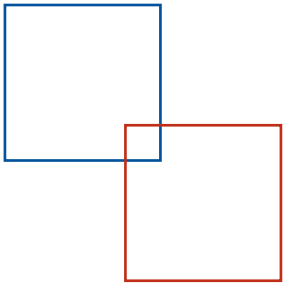


Health Benefits Resource Guide

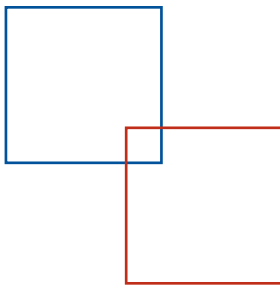


Introduction

Whether you are newly hired or a career veteran, selecting a health benefit plan can be complicated. As a federal or postal employee you have a wide range of health plans and types of coverage from which to choose. This guide includes information that will help you:

- **Understand the types of plans offered (HMO, FFS/PPO, or HDHP)**
- **Understand general health benefit terms**
- **Evaluate your health benefit needs**
- **Make a value-based decision when choosing a health plan**
- **Get answers to some frequently asked questions**
- **Learn about the Mail Handlers Benefit Plan**
- **Access resources available to you**

This brochure is provided for descriptive purposes only. Please refer to the official brochure of the plan(s) in which you are interested before making a final decision.



Health Plan Options

The Federal Employee Health Benefits Program (FEHBP) provides health benefits coverage to over eight million people. A range of health plan options are available to you depending on where you live and work.

There are three main types of health plans offered through FEHBP:

- **Health Maintenance Organizations (HMO)**—Health plans that provide care through contracted or employed physicians and hospitals located in particular geographic or service areas. Your eligibility to enroll in an HMO is determined by where you live or, in some plans, where you work. Many HMOs have network provider restrictions, which means that you must use in-network providers for services to be covered. Out-of-network coverage is typically limited to emergencies. You may have to choose a primary care physician (PCP) and have all care coordinated through that physician. Your PCP is typically responsible for obtaining any precertification required for inpatient admissions or other services or procedures.
- **Fee-for-Service plans (FFS)/Preferred Provider Organizations (PPO)**—Health coverage in which doctors and other providers receive a fee for each service such as an office visit, test, procedure, or other health care service. These plans reimburse you or your health care provider for the allowable cost under the plan for covered services. You may choose your own physician, hospital, and other health care providers. Most fee-for-service plans have preferred provider (PPO) arrangements nationwide. If you receive services from a preferred provider, you usually have lower out-of-pocket expenses because of the PPO network discounts and other features like a smaller copayment and/or a reduced or waived deductible. All fee-for-service plans require precertification of inpatient admissions and may require preauthorization of certain procedures or other services.
- **High Deductible Health Plan**—A High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) provides traditional medical coverage and also helps you build savings for future medical expenses. These plans carry a substantially higher deductible than other plans, but also offer you greater flexibility and discretion over how you spend your health care dollars.

When you enroll in an HDHP, the health plan determines if you are eligible for a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA). If you are enrolled in Medicare or are covered by another health plan that is not an HDHP, you are not eligible for an HSA. Each month, the plan automatically credits a portion of the health plan premium into your account, based on your eligibility as of the first day of the month. You can pay for your health care expenses, including your deductible, copayment amounts and more, with funds from your HSA or HRA. If you have an HSA, you can also choose to pay your health care expenses out-of-pocket, allowing your savings account to grow.

To learn more about the health plan options available to you, contact your agency human resources office or retirement system, or visit www.opm.gov/insure.

Understanding Health Plan Features

The plan features provided below describe how these types of plans generally work. Because there may be exceptions, you should review the official brochure of the plan(s) in which you are interested before making a final decision.

HMO Key Features:

- Limits the doctors and other providers you can use—coverage may be restricted to the plan’s service area.
- No out-of-network benefits, except for emergencies.
- Referrals to see specialists may be required.
- Enrollment with a Primary Care Physician (PCP) may be required.
- You usually pay only copayments for your care and there is no deductible.
- Comprehensive preventive care benefits are offered.

PPO Key Features:

- No geographic restrictions on the doctors and other providers you can use—national coverage.
- Out-of-network benefits are provided (some plans also provide overseas coverage).
- Referrals are not required to see specialists.
- See any provider you want at anytime—no PCP enrollment required.
- You typically pay copayments or coinsurance when you receive care.
- There is usually an annual deductible (applies to certain benefits).
- Preventive care benefits are typically available with no deductible when PPO providers are used.

HDHP w/HSA Key Features:

- Depending on the plan, you may have a choice of in-network and out-of-network providers. Using in-network providers will save you money.
- Preventive care services are generally paid as first dollar coverage, or after a small deductible or copayment. A maximum dollar amount (e.g., up to \$300) may apply.
- With the exception of preventive care, you pay all out-of-pocket costs until the annual deductible is met.
- You pay copayments or coinsurance for your care after the annual deductible is met.
- The plan deposits money into your HSA for you to use on IRS qualified medical expenses or to save for the future—unused funds roll over year after year and can earn interest.
- You own the HSA and it is yours to keep—even when you change plans, employers, or retire.
- Funds deposited into the HSA by you or the health plan are federal tax free. There is a penalty for withdrawing funds before age 65 that are not used for qualified medical expenses.
- A debit card may be provided to give you convenient access to your HSA funds.
- You play a critical role in managing your care, healthcare costs and your HSA/HRA.

Evaluating a Health Plan

As you research health plans, it's important to look for the **best value**. Don't get caught up on the plan name (e.g., Standard Option, High Option, etc.). Remember, value is a balance of many factors such as provider choice, coverage, cost and what works best for you.

Health Care Providers (Is my doctor in the network? Is access available where I need it?)

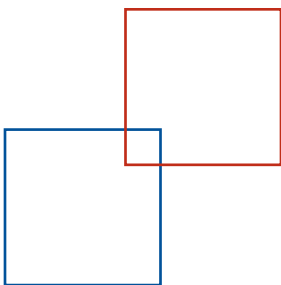
- Determine if you need a local plan or a plan with national coverage. If you travel frequently or have children away in college you may want a national health plan.
- Confirm your provider's participation in the network by calling the health plan before you enroll.
- Make sure the provider types/specialists you need are included in the network (e.g., dermatologist, oncologist, hematologist, and gynecologist).
- Review any requirements the plan may have for getting care through a specialist.

Tip: Choose providers that participate in your health plan's network. You will maximize your benefits and save money.

Coverage (What services/expenses do my benefits cover and what do I need?)

- Read the health plan information and benefit descriptions (official plan brochure) to learn what medical expenses and services are covered by the plans you are considering.
- Check coverage for any services you expect you will need (e.g., annual checkup, family planning, chiropractic care or overseas coverage).
- Consider your utilization of services (i.e., how often you expect to use certain services). Review any limitations or exclusions for certain services you may need. Plan exclusions are listed in the official plan brochure.
- Review the plan's drug formulary to determine whether any medications you may be taking are covered and how much they will cost you. A formulary is a list of prescription drugs that are preferred by your health plan based on safety, effectiveness, and cost.

Tip: Make a list of the medical services you will need and call the plan(s) you are considering to confirm what is covered. It's important to select a plan with benefits that best meet your needs.



Evaluating a Health Plan

Cost (How much will I have to pay?)

When trying to predict your annual health care costs, you want to look at five key elements: premium, deductible, copayment, coinsurance and the catastrophic protection limit.

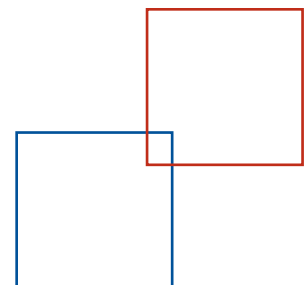
- **Premium**—The cost of health insurance—this amount is deducted from your bi-weekly paycheck. Premiums can vary across the benefit plans offered to you.
- **Deductible**—The amount you must pay for health care before your health plan begins to pay. Deductibles typically apply on a per-calendar-year basis. There may be separate deductibles for different types of services. Deductibles can change from year to year.
- **Copayment**—A fixed dollar amount that you pay as your share of the cost of medical services you receive (e.g., \$20 for a doctor's visit).
- **Coinsurance**—A percentage of the cost you pay as your share of the medical services you receive (e.g., 20% of the cost of a lab test).
- **Catastrophic Protection Limit**—The maximum amount of certain covered charges you have to pay out of your pocket during the year. Setting a maximum amount protects you. Separate limits are usually applied on a per person and per family basis.

Tip: As you consider cost, keep in mind the services you use most often and services that you need or want. This will give you a good indication of your potential out-of-pocket costs.

Service (Will this health plan be there for me?)

You should contact the plan *before* you become a member to test their customer service. When you call, you can assess how easy it is to reach a real person and get answers to your questions. If your co-workers are enrolled in the health plan you are considering, ask them to rate their experience.

Tip: Good service is essential to your benefits working for you. Choose a plan that has knowledgeable service representatives who are able to answer your questions.



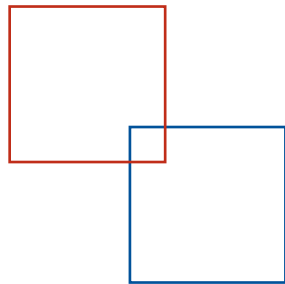
Dental & Vision Coverage

FEDVIP Plans

Federal employees, retirees, and their dependents may purchase dental and vision coverage through the Federal Employee Dental and Vision Insurance Program (FEDVIP). The FEDVIP is an enrollee-pay-all program, which means there is no government contribution. Premiums for enrolled federal and postal employees are withheld from salary on a pre-tax basis. New hires can enroll within 60 days of their employment date. All FEHB-eligible enrollees can enroll or change their FEDVIP enrollment during the Open Season. For more information about FEDVIP visit www.opm.gov/insure or consult your agency's human resources office.

Supplemental Plans

In addition to the FEDVIP plans, there are supplemental dental and vision plans available from some of the health plans participating in FEHBP. You can enroll in many of these plans year round. Supplemental benefits are neither offered nor guaranteed under contract with the FEHB Program, but are made available to all persons who are eligible for FEHBP coverage. You cannot file a FEHB disputed claim about them. The premiums and fees you pay for those services do not count toward FEHB deductibles or catastrophic protection limits.



Opportunities to Change Coverage

During the annual FEHBP Open Season anyone eligible to participate in the FEHB Program may enroll, change health plans or options, cancel FEHB enrollment, or change participation in premium conversion (waive or begin participation). The official start and end dates of Open Season are determined by OPM each year. Open Season generally runs from the Monday of the second full work week in November through the Monday of the second full work week in December.

Outside of Open Season there are limited opportunities to make enrollment changes. Newly eligible employees may enroll within 60 days of becoming eligible for the program. Members who move outside of the area covered by their current health plan may also be allowed to switch to a different plan. There are other circumstances that may make you eligible to enroll or change your FEHB coverage outside of Open Season, such as changes in marital or family status. For more information on qualifying life events, or how to enroll, visit www.opm.gov/insure or consult your agency's human resources office.

Federal Resources

Office of Personnel Management (OPM)

Visit www.opm.gov or contact your employing or retirement office when you have questions about your employment and benefits. This website offers information such as forms, news, tools and resources, and OPM publications.

Medicare

Call 1-800-MEDICARE (**1-800-633-4227**) or visit www.medicare.gov to learn more about enrolling in Medicare.

Social Security Administration

Contact them about social security benefits, retirement, Medicare programs and more. Visit www.ssa.gov or call **1-800-772-1213**.

First Gov

Get links to federal government and state and local agencies when you visit www.FirstGov.gov.

National Active and Retired Federal Employees (NARFE)

Federal employees and retirees can visit www.narfe.org for information about benefits and updates on legislation affecting federal retirees.

Frequently Asked Questions

Who is eligible to enroll in a FEHB Program?

As a federal employee, you are entitled to enroll yourself and any eligible family members in a health plan offered under the FEHB Program, unless your position is excluded from coverage by law or regulation.

What are the enrollment levels?

There are two types of enrollment: Self Only and Self and Family. A Self Only enrollment provides benefits only for you as the enrollee. You may enroll for Self Only even though you have a family, but your family members will not be eligible for FEHB coverage (even upon your death or disability). A Self and Family enrollment covers you, your spouse, and your unmarried dependent children under age 22.

What are enrollment codes?

An enrollment code identifies the plan, the option (e.g., High or Standard), and the type of enrollment (Self Only or Self and Family) you have chosen. The first two places in the three-digit code identify the plan, and the third position identifies the option and type of enrollment. Enrollment codes are found on the front and back covers of each plan's brochure and in the Guide to Federal Benefits (RI 70-1).

Up to what age are dependent children covered?

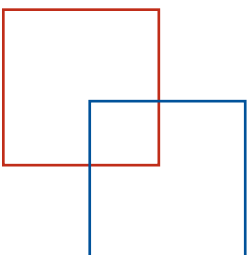
In FEHBP, your dependent children can be covered under your Self and Family enrollment until they marry or turn age 22. In some cases, dependent children over age 22 may be covered if they are incapable of self-support. Consult your agency's human resources office for more information.

Are pre-existing conditions covered?

Yes. When you enroll in FEHBP during Open Season or as a new hire, there are no exclusions or waiting periods for pre-existing conditions in any plan in the FEHB Program.

What is an Official Plan Brochure?

You may receive informational or promotional brochures from health plans, but always refer to the official plan brochure before making any decisions. Plan brochures contain complete information on your benefits including exclusions, limitations, and other major provisions. Each plan issues a new brochure for each calendar year. You can get copies of the brochures for the various plans that you are eligible to join so you can make an informed choice. You can access all plan brochures at www.opm.gov/insure. You can also get brochures from your employing office, or by contacting the health plans directly. You should keep your plan's current brochure as a reference on the benefits that your plan provides.



Frequently Asked Questions

How can I find out if a doctor or hospital is in the network?

All health plans with preferred provider arrangements make available a participating provider directory that lists participating physicians, hospitals, and other providers. Every year during Open Season, you should verify your chosen provider's continued participation in the plan. Most plans have electronic provider directories on their websites. These can be accessed from the FEHB home page or directly from the health plan's website. You can also call the health plan to determine if your provider participates in their network. If you enroll in a fee-for-service plan, you should always verify the provider's participation when you make an appointment.

Note: *The continued participation of any provider with a health plan is not guaranteed. You are not eligible to change plans outside of Open Season solely because a particular health care provider stops participating in your plan's network.*

Am I permitted to change health plans even if I may be retiring soon?

Yes. Generally the federal government requires that you are enrolled in any FEHBP plan for five continuous years prior to retiring in order to take your health benefits into retirement. *You are not required to stay with the same health plan during this five-year period.* You are completely free to switch health plans without compromising your eligibility for retirement benefits.

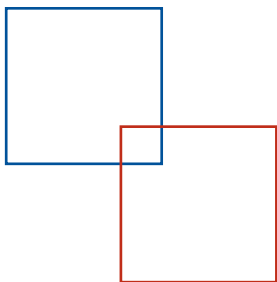
How are health plan premiums determined?

Each health plan carrier under the FEHB Program charges a different premium. For federal employees, the Government pays up to 75% of the cost of your health benefits coverage, and you pay the remainder, based on a formula set by law.

Why are health plan premiums for postal employees lower than other federal employees?

The Postal Service contributes a greater share of the total health care premium on behalf of its employees than the federal government.

Get more answers to frequently asked questions when you visit www.opm.gov/insure/health/faq/index.asp



About **MHBP**

The **Mail Handlers Benefit Plan (MHBP)** is a nationwide fee-for-service PPO plan that was created in 1963. It is sponsored by the National Postal Mail Handlers Union (NPMHU). MHBP has been serving federal and postal employees and annuitants for over 45 years.

MHBP IS OPEN TO EVERYONE—federal and postal employees and annuitants.

Our plans at a glance:

- **Value Plan**

With one of the lowest rates in the FEHBP, this money-saving PPO plan offers you super-low premiums, great benefits and more. As MHBP's most affordable plan, it's perfect if you want to save money on your premiums while getting valuable health coverage.

- **Standard Option**

Get comprehensive health coverage and competitive rates with MHBP Standard Option. Even better, this plan's predictable copays and low out-of-pocket costs let you take the guesswork out of your health care expenses.

- **Consumer Option**

You are in control of your health care spending with our high-deductible health plan with a health savings account (HSA). This PPO plan puts up to \$1,690 tax-free into your HSA, pays 100% of your PPO preventive care and provides top-notch coverage after your deductible is met.

- **Supplemental Dental and Vision Plans**

The Mail Handlers Benefit Plan offers federal and postal employees and annuitants dental and vision supplemental benefits. Expand your health coverage when you add one or both of our affordable options. These plans offer great benefits, national coverage and affordable monthly rates.



MHBP Value Plan

Get valuable coverage and savings on your premium!

The MHBP Value Plan is perfect if you want to pay less for your health coverage and still get the benefits you need. This PPO plan balances your need for great health benefits, preventive care and catastrophic protection while saving you serious money on your premiums.

2009 MHBP Value Plan Rates				
	Enrollment Code	Federal Employees (Biweekly)	Postal Employees (Biweekly)	Annuitants (Monthly)
Self Only	414	\$21.53	\$11.63	\$46.65
Self & Family	415	\$51.33	\$27.72	\$111.22

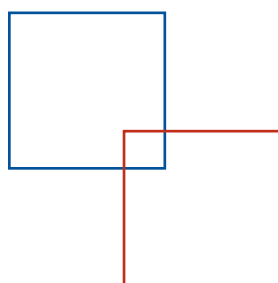
These rates don't apply to all enrollees. If you're in a special enrollment category, please refer to your Guide to Federal Benefits or contact the agency that maintains your health benefits enrollment.

MHBP Value Plan continues to offer one of the lowest rates in the FEHBP, along with the health benefits you want—including PPO benefits that give you **100% coverage, with no deductible for:**

- Annual physical exams
- Preventive care screenings
- Primary care doctor visits (after a \$30 copay)
- Maternity care
- Well-child care and immunizations
- Lab tests (with Quest® Diagnostics)

Plus, you have coverage for other doctor's office visits, hospitalizations, emergency care and outpatient surgery. You can even fill your generic prescriptions at a network pharmacy for a low \$10 copay. And, you get special discounts on hearing, vision and fitness services.

See our official Plan brochure for a complete description of Value Plan benefits.



2009 MHBP Value Plan Benefits

Medical Coverage	You Pay	
	PPO	Non-PPO
Calendar-Year Deductible	\$500 per person, limited to \$1,000 per family	\$800 per person, limited to \$1,600 per family
<i>We added "(No deductible)" to show when the calendar-year deductible does <u>not</u> apply.</i>		
Adult Preventive Care <i>(Annual Physical Exam, Screenings and Immunizations)</i>	Nothing (No deductible)	Not covered
Well-Child Care <i>(Well-child Visits, Screenings and Immunizations)</i>	Nothing (No deductible)	Not covered
Maternity Care	Nothing (No deductible)	40% of the Plan's allowance and any difference between our allowance and the billed amount
Primary Care Doctor's Office Visits <i>(Family Practice, General Practice, Pediatrician and Internal Medicine)</i>	\$30 copayment per office visit (No deductible)	40% of the Plan's allowance and any difference between our allowance and the billed amount
Non-Primary Care Doctor's Office Visits	20% of the Plan's allowance	40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab, X-ray and Diagnostic Tests	20% of the Plan's allowance	40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program	Nothing for covered lab tests with the Lab Savings Program with Quest® Diagnostics (No deductible)	
Chiropractic Care	20% of the Plan's allowance and all charges after the Plan has paid the \$2,500 combined alternative, chiropractic and rehabilitative therapies maximum	Not covered
Hospitalization	20% of the Plan's allowance	40% of the Plan's allowance and any difference between our allowance and the billed amount
Outpatient Surgical Facility	\$200 copayment per occurrence (No deductible)	40% of the Plan's allowance and any difference between our allowance and the billed amount
Surgery <i>Outpatient</i>	Nothing (No deductible)	40% of the Plan's allowance and any difference between our allowance and the billed amount
	<i>Inpatient</i>	
Anesthesia	20% of the Plan's allowance	40% of the Plan's allowance and any difference between our allowance and the billed amount
Emergency Treatment	20% of the Plan's allowance	40% of the Plan's allowance and any difference between our allowance and the billed amount
Overseas Medical Expenses	PPO-level benefits apply for covered care received outside the United States	
Catastrophic Protection <i>(Some costs do not count toward this protection)</i>	Nothing after your out-of-pocket expenses for covered services from PPO providers totals \$4,000 per calendar year	Nothing after your out-of-pocket expenses for covered services from PPO providers and non-PPO providers combined totals \$6,000 per calendar year

Prescription Drug Coverage	You Pay	
	Network Pharmacy and Electronic Claims	Non-Network Pharmacies and Paper Claims
Retail Pharmacy—Up to a 30-day supply	No deductible	
Generic	\$10 copayment	Not covered
Non-Generic	50% of the Plan's allowance	Not covered
Mail-Order Pharmacy—Up to a 90-day supply	No deductible	
Generic	\$30 copayment	Not covered
Non-Generic	50% of the Plan's allowance	Not covered

Special Member Benefits*

Vision care discounts and savings from EyeMed Vision Care providers, laser vision correction savings from the U.S. Laser Network and QualSight, a hearing aid discount program from HearPO, and healthy living and fitness benefits from GlobalFit.

*These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all MHBP participants and their covered family members. You cannot file a FEHBP disputed claim about them. The fees you pay for these services do not count toward FEHBP deductibles or out-of-pocket maximums.

This is a summary of the Mail Handlers Benefit Plan Value Plan. Before making a final decision, please read the 2009 official Plan brochure (RI 71-007). All benefits are subject to the definitions, limitations and exclusions set forth in the 2009 official Plan brochure. A single annual \$42 MHBP associate membership fee makes the Value Plan available to you.

MHBP Standard Option

A winning combination of practical coverage and predictable costs!

The MHBP Standard Option is perfect if you want comprehensive health coverage and predictable low copays. Manage your health expenses and get the care you need.

Competitive premiums—Compare Standard Option rates against other plans you may be considering.

2009 MHBP Standard Option Rates				
	Enrollment Code	Federal Employees (Biweekly)	Postal Employees (Biweekly)	Annuitants (Monthly)
Self Only	454	\$59.86	\$36.07	\$129.70
Self & Family	455	\$128.66	\$74.80	\$278.76

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

Comprehensive coverage—Get extensive benefits that cover basic preventive care (e.g., annual physicals and screenings), major surgery and hospitalizations, plus other valuable discounts for hearing, vision and fitness.

PPO benefits that give you 100% coverage with no deductible for:

- Adult annual physical exams (after a \$20 copay)
- Wellness screenings (such as mammograms, cholesterol tests and prostate exams)
- Maternity care (including prenatal, delivery and postnatal)
- Well-child care
- Lab tests (with Quest® Diagnostics)

Predictable out-of-pocket costs that help you budget when you use PPO providers:

- \$20 adult office visit copay (\$10 for dependents under age 22)
- \$10 copay for generic medications
- \$15 copay for chiropractic visits (up to a \$2,500 maximum, includes alternative and rehabilitative therapies combined)

See our official Plan brochure for a complete description of Standard Option benefits.

2009 MHBP Standard Option Benefits

Medical Coverage	You Pay	
	PPO	Non-PPO
Calendar-Year Deductible	\$350 per person, limited to \$700 per family	\$500 per person, limited to \$1,250 per family
<i>We added "(No deductible)" to show when the calendar-year deductible does not apply.</i>		
Annual Physical Exam for Adults <i>(age 18 and over)</i>	\$20 copayment (No deductible)	Not covered
Well-Child Care	Nothing (No deductible)	All charges after the Plan has paid \$75 per child per calendar year (No deductible)
Preventive Screenings <i>(Includes cholesterol screenings, mammograms, Pap tests, PSA tests, urinalysis, bone density screenings, colon cancer screenings, and more)</i>	Nothing (No deductible)	30% of the Plan's allowance and any difference between our allowance and the billed amount
Maternity Care	Nothing (No deductible)	30% of the Plan's allowance and any difference between our allowance and the billed amount
Doctor's Office Visits	\$20 copayment per office visit for adults, \$10 copayment for dependent children under age 22 (No deductible)	30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Lab, X-ray and Diagnostic Tests	10% of the Plan's allowance	30% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program	Nothing for covered lab tests with the Lab Savings Program with Quest® Diagnostics (No deductible)	
Chiropractic Care	\$15 copayment per office visit, and all charges after the Plan has paid the \$2,500 combined alternative, chiropractic and rehabilitative therapies maximum (No deductible)	30% of the Plan's allowance and any difference between our allowance and the billed amount, and all charges after the Plan has paid the \$2,500 combined alternative, chiropractic and rehabilitative therapies maximum (No deductible)
Hospitalization <i>Maternity</i>	\$200 per-admission copayment, nothing for covered room & board and 15% of the Plan's allowance for hospital ancillary services (No deductible) Nothing (No deductible)	\$400 per-admission copayment, 30% of the Plan's allowance and any difference between our allowance and the billed amount (No deductible)
Surgery and Anesthesia	10% of the Plan's allowance	30% of the Plan's allowance and any difference between our allowance and the billed amount
Emergency Treatment	\$50 copayment at an urgent care center, \$150 copayment at a hospital emergency room. Hospital ER copayment waived if admitted. No deductible for accidental injury.	30% of the Plan's allowance and any difference between our allowance and the billed amount
Overseas Medical Expenses	PPO-level benefits apply for covered care received outside the United States	
Catastrophic Protection <i>(Some costs do not count toward this protection)</i>	Nothing after your out-of-pocket expenses for covered services from PPO providers totals \$4,500 per calendar year	Nothing after your out-of-pocket expenses for covered services from PPO providers and non-PPO providers combined totals \$9,000 per calendar year

Prescription Drug Coverage	You Pay	
	Network Pharmacy and Electronic Claims	Non-Network Pharmacies and Paper Claims
Retail Pharmacy—Up to a 30-day supply	No deductible	
Generic	\$10 copayment	50% of the Plan's allowance and any difference between our allowance and the billed amount
Preferred brand name	\$40 copayment	
Non-Preferred brand name	\$60 copayment	
Specialty†	\$100 copayment	
Mail-Order Pharmacy—Up to a 90-day supply	No deductible	
Generic	\$15 copayment	Not covered
Preferred brand name	\$65 copayment	
Non-Preferred brand name	\$90 copayment	
Specialty†	\$300 copayment	

Special Member Benefits*

Vision care discounts and savings from EyeMed Vision Care providers, laser vision correction savings from the U.S. Laser Network and QualSight, a hearing aid discount program from HearPO, and healthy living and fitness benefits from GlobalFit.

*These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all MHBP participants and their covered family members. You cannot file a FEHBP disputed claim about them. The fees you pay for these services do not count toward FEHBP deductibles or out-of-pocket maximums.

This is a summary of the Mail Handlers Benefit Plan Standard Option. Before making a final decision, please read the 2009 official Plan brochure (RI 71-007). All benefits are subject to the definitions, limitations and exclusions set forth in the 2009 official Plan brochure. A single annual \$42 MHBP associate membership fee makes the Standard Option available to you.

†Specialty drugs are used to treat chronic, complex conditions and typically require special handling and close monitoring.

MHBP Consumer Option

Your care. Your choice. Your money.

MHBP Consumer Option is our high-deductible health plan with a health savings account (HSA) that lets you decide how and when you spend your health care dollars.

The health benefits you get:

- 100% coverage for your preventive care needs (physical exams, screenings, immunizations, mammograms, Pap tests and more) when you use PPO providers—and no deductible applies
- You fully pay for non-preventive health care until the deductible is met—your HSA funds can help
- After your deductible is met, your comprehensive coverage kicks in and MHBP pays the majority of your medical expenses for covered care

The health savings account you control:

- Get up to \$845 annually in your account, deposited monthly, for Self Only coverage, or up to \$1,690 annually for Self & Family coverage
- Use your convenient debit card to pay for things like doctor visits, prescription drugs or other IRS-qualified medical expenses
- Save your HSA money and let it roll over from year to year, or use the money as you need care—it's up to you
- Opportunities to invest funds over \$1,000
- HSA funds remain yours if you retire, change jobs or leave federal service—there's no "use it or lose it" rule

The tax benefits you enjoy

All of the funds we deposit into your HSA are federal tax-free. And, any money you contribute to your account is also tax-free, up to the IRS-defined limits.

All of these benefits assume the use of PPO providers and network pharmacies, and that you are eligible to have an HSA under federal tax laws.

2009 MHBP Consumer Option Rates				
	Enrollment Code	Federal Employees (Biweekly)	Postal Employees (Biweekly)	Annuitants (Monthly)
Self Only	481	\$34.82	\$18.80	\$75.44
Self & Family	482	\$78.90	\$42.61	\$170.95

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

See our official Plan brochure for a complete description of Consumer Option benefits.

2009 MHBP Consumer Option Benefits

Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA, if you are not eligible for an 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)	\$2,155 (Self Only); \$4,260 (Self & Family)	Not applicable

Deductible	Self Only	Self & Family
Calendar Year Deductible	\$2,000	\$4,000

The calendar year deductible applies to most benefits. We added "(No deductible)" to show when the calendar year deductible does not apply.

PPO Preventive Care	You Pay	
Benefit Description	PPO	Non-PPO
Routine Physical Exam & Immunizations	Nothing (No deductible)	Not covered
Routine Preventive Screenings	Nothing (No deductible)	Not covered

Traditional Medical Coverage <i>(Deductible must be met before benefits begin)</i>	You Pay	
Doctor's Office Visits	\$15 copayment per office visit, including associated testing	40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab, X-ray and Diagnostic Tests	\$15 copayment per office visit, including associated testing	40% of the Plan's allowance and any difference between our allowance and the billed amount
Lab Savings Program	Nothing for covered lab tests with the Lab Savings Program with Quest® Diagnostics	
Chiropractic Care	\$15 copayment per office visit, and all charges after the Plan has paid the \$2,500 combined alternative, chiropractic and rehabilitative therapies maximum	40% of the Plan's allowance and any difference between our allowance and the billed amount, and all charges after the Plan has paid the \$2,500 combined alternative, chiropractic and rehabilitative therapies maximum
Hospitalization	Nothing for covered room & board and \$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
Outpatient Surgical Facility	\$150 copayment per occurrence	40% of the Plan's allowance and any difference between our allowance and the billed amount
Surgery and Anesthesia	Nothing in hospital; \$15 copayment in doctor's office	40% of the Plan's allowance and any difference between our allowance and the billed amount
Emergency Treatment	\$50 copayment per occurrence	40% of the Plan's allowance and any difference between our allowance and the billed amount
Overseas Medical Expenses	PPO-level benefits apply for covered care received outside the United States	
Catastrophic Protection <i>(Some costs do not count toward this protection)</i>	Nothing after your out-of-pocket expenses for covered services from PPO providers totals \$5,000 per calendar year for Self Only enrollment (\$10,000 for Self & Family enrollment)	Nothing after your out-of-pocket expenses for covered services from PPO providers and non-PPO providers combined totals \$7,500 per calendar year for Self Only enrollment (\$15,000 for Self & Family enrollment)

Prescription Drug Coverage <i>(Deductible must be met before benefits begin)</i>	You Pay	
Benefit Description	Network Pharmacy and Electronic Claims	Non-Network Pharmacies and Paper Claims
Retail Pharmacy—Up to a 30-day supply		
Generic	\$10 copayment	Not covered
Preferred brand name	\$25 copayment	Not covered
Non-Preferred brand name	\$40 copayment	Not covered
Mail-Order Pharmacy—Up to a 90-day supply		
Generic	\$20 copayment	Not covered
Preferred brand name	\$50 copayment	Not covered
Non-Preferred brand name	\$80 copayment	Not covered

Special Member Benefits*

Vision care discounts and savings from EyeMed Vision Care providers, laser vision correction savings from the U.S. Laser Network and QualSight, a hearing aid discount program from HearPO, and healthy living and fitness benefits from GlobalFit.

*These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all MHBP participants and their covered family members. You cannot file a FEHBP disputed claim about them. The fees you pay for these services do not count toward FEHBP deductibles or out-of-pocket maximums.

This is a summary of the Mail Handlers Benefit Plan Consumer Option. Before making a final decision, please read the 2009 official Plan brochure (RI 71-007). All benefits are subject to the definitions, limitations and exclusions set forth in the 2009 official Plan brochure. A single annual \$42 MHBP associate membership fee makes the Consumer Option available to you.

MHBP Supplemental Dental and Vision Plans

Expand your health coverage when you add one or both of our affordable options. You can enroll in these plans year round!

MHBP Supplemental Vision Plan

- Eye exams & lenses every 12 months for just a \$10 copayment each
- Up to \$120 for frames (every 24 months) or contact lenses (every 12 months)
- Discounted rates for laser vision correction
- Access to more than 26,000 VSP network providers nationwide
- No ID card necessary and no claim forms required
- Out-of-network benefits too

MHBP Supplemental Dental Plan

- Vast provider selection—over 110,000 dental PPO locations nationwide
- No claim forms to file—PPO dentists do it for you!
- Benefits that increase the longer you are enrolled

Call today for dental rates and get your coverage started right away! Call us at 1-800-254-0227 or enroll online at www.mhbp.com.

Low Monthly Vision Rates!

– \$8.60 Self

– \$16.00 Self & Family

Summary of PPO Dental Benefits				
Benefit Category	Calendar Year Deductible	First Year [1st-12th month of coverage]	Second Year [13th-24th month of coverage]	Third Year [25th month of coverage and later]
Preventive Care Exams, cleanings and bitewing x-rays	No Deductible	100%	100%	100%
Basic Services Fillings, extractions and other x-rays	\$50 per person, up to \$150 per family	70%	80%	80%
Major Services Root canals, crowns and bridges		Benefits begin in second year	50%	50%
Orthodontia (children 18 and under, \$1,000 lifetime benefit maximum)		Benefits begin in third year		50%

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Frequently Asked Questions

MHBP General FAQs

Who can enroll in the MHBP?

The Mail Handlers Benefit Plan is Open to Everyone—federal and postal employees and annuitants alike.

Do I have to be a union member to enroll with MHBP?

The Plan is sponsored by the National Postal Mail Handlers Union (NPMHU), but you don't have to be a Union member to enroll. You don't even have to work for the U.S. Postal Service—MHBP is open to ALL federal and postal employees and annuitants. However, if you are not a NPMHU member, an associate membership fee of \$42 annually will be required to participate in the health plan. Other privileges are also available to you as an associate member, including supplemental programs for dental and vision care benefits and other discounts.

Is MHBP a PPO or an HMO?

MHBP is a national PPO plan. You are covered no matter where you live, work or travel nationwide. You have complete freedom of choice and flexibility with MHBP.

Why should I choose MHBP?

The MHBP has proudly served the federal population for over 45 years. We have a

solid track record of delivering value for your money and unparalleled 24/7 customer service. Our health plans cater to the needs of single, married, employed or retired persons. Whatever your stage of life or health status, you can count on MHBP to be there for you—making things easier!

What area(s) does your network cover?

Our nationwide network covers all 50 states, the District of Columbia and Puerto Rico. We have over 590,000 health care providers and 4,600 hospitals participating in our network. You're even covered outside the U.S.—your PPO benefits go wherever you go.

Is enrollment with a primary care physician (PCP) required?

No. You can see any physician you choose. PCP enrollment is not required.

Are referrals required to see a specialist?

No. MHBP does not require referrals to see a specialist.

Are non-network benefits available?

Yes. With MHBP you can see non-network providers and receive benefits for covered care. However, you get the highest level of benefit when you use network providers. Some benefits (e.g., annual physicals) may require the use of network providers. Refer to the official Plan brochure for more details.

Contact Us

MHBP Telephone Numbers

Mail Handlers Benefit Plan

1-800-410-7778

TTY/TDD for Hearing Impaired

1-800-852-7195

Overseas Enrollees*

1-480-445-5106

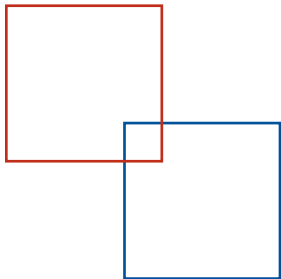
*For a list of overseas toll-free numbers, visit www.mhbp.com

MHBP Supplemental Dental and Vision Plans

1-800-254-0227

MHBP Website

www.mhbp.com



To obtain more information about MHBP, please contact us anytime at **1-800-410-7778** or visit us online at **www.mhbp.com**.

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This informational brochure is brought to you by the Mail Handlers Benefit Plan (MHBP). MHBP is a nationwide fee-for-service PPO plan that is sponsored by the National Postal Mail Handlers Union. MHBP has been serving federal and postal employees and annuitants for over 45 years. Our plan is open to all federal and postal employees and annuitants.

