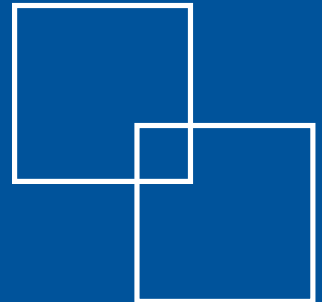


Open to Everyone

MHBP SM

Health Benefits *Resource Guide*

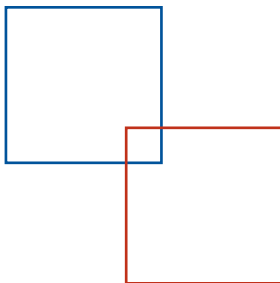


Introduction

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**
- **Access resources available to you**
- **Learn about MHP**

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 a 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 a 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's 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 may not be a deductible.
- Comprehensive preventive care benefits are provided.

PPO Key Features:

- No geographic restrictions on the doctors and other providers you can use; you have nationwide coverage. Plans may also provide overseas coverage.
- Out-of-network benefits are provided.
- 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 services are covered, but mostly 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 paid as first dollar coverage.
- 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 tax 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, health care costs and your HSA/HRA.

Evaluating a Health Plan

As you research health plans, it is 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.

Provider Choice (Is my doctor in the network? Is access available where I need it?)

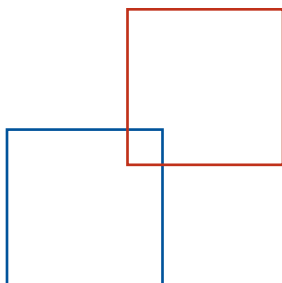
- Determine if you need a local plan or a plan with national coverage. If you travel frequently or have children away in college you may want a national health plan.
- Confirm your provider's participation in the network by calling the health plan and the provider before you enroll.
- Make sure the provider types and specialists you need are included in the network (e.g., dermatologist, oncologist, ophthalmologist, gynecologist, etc.).
- 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., 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 if the medications you take 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.

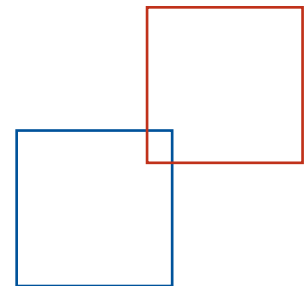
- **Premium**—The cost of health insurance—this amount is deducted from your biweekly paycheck. Premiums can vary across the benefit plans offered to you.
- **Deductible**—The amount you must pay for health care before your health plan begins to pay. Deductibles typically apply on a per-calendar-year 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 for 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 experience 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.



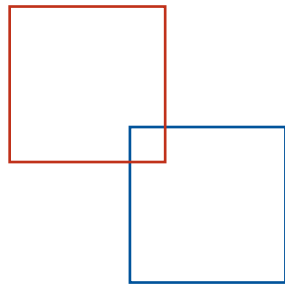
Dental & Vision Coverage

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.

Other Dental and Vision

In addition to the FEDVIP plans, there are other dental and vision plans available from some of the health plans participating in FEHBP. You can enroll in many of these plans year round. These 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, or if you or a covered dependent qualify for Temporary Continuation of Coverage (TCC). 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**.

USA.gov

Get links to federal government and state and local agencies when you visit www.USA.gov or call **1-800-333-4636**.

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. Your agency's human resources personnel can help you determine your eligibility.

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 generally covers you, your spouse, and your dependent children under age 26.

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 for Federal Civilian Employees (RI 70-1).

Up to what age are dependent children covered?

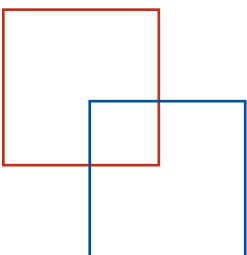
In FEHBP, your dependent children can be covered under your Self and Family enrollment until age 26. In some cases, dependent children over age 26 may be covered if they are incapable of self-support. Consult your agency's human resources office for more information.

Are pre-existing conditions covered?

Yes. 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 produces a new brochure every calendar year. You should review the brochures for the plans that you are eligible to join to help you make an informed choice. You can access all plan brochures at www.opm.gov/insure. You can also obtain 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. You should always verify your chosen provider's continued participation in the plan's network. Most plans have electronic provider directories on their websites. You can also call the health plan to determine if your provider participates in their network.

***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 the five years of service immediately preceding retirement, or if less than five years, for all service since your first opportunity to enroll 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?

The total premium for a specific health plan is the same for all enrollees, but the Government contribution is based on your employment. Per FEHB law, the government will pay the lesser of 75% of the carrier's total premium or 72% of the average premium. Some agencies, such as the Postal Service, contribute additional money towards the total premium. As a result, the share you must pay will depend upon your employment status. The enrollee is responsible for the difference between the government contribution and the total premium. If the average premium increases, the maximum government contribution also increases.

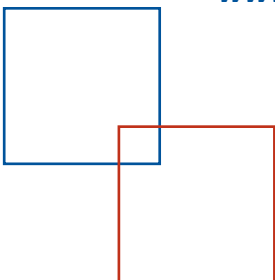
Why are health plan premiums for postal employees lower than other federal employees?

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 and other information when you visit:

www.opm.gov/insure/health/faq/index.asp or

www.opm.gov/insure/fastfacts/index.asp



About **MHBP**

The **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 48 years.

MHBP IS OPEN TO EVERYONE

Our plans at a glance:

- **Value Plan**

Enjoy affordable premiums, great benefits and more. This health plan is perfect if you want to save money on your premiums while getting valuable health coverage.

- **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 annually, pays 100% of your PPO preventive care and provides top-notch coverage after your deductible is met.

- **Standard Option**

Get comprehensive health coverage 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.

- **Dental and Vision**

The MHBP offers federal and postal employees and annuitants dental and vision benefits. Expand your 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.

MHBP Value Plan 2012 Rates	Federal Biweekly	Postal		Annuitants Monthly
		Category 1 Biweekly	Category 2 Biweekly	
Self Only – 414	\$39.59	\$26.13	\$24.54	\$85.77
Self and Family – 415	\$94.38	\$62.29	\$58.52	\$204.49

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
- Convenient Care Clinic visits (e.g., clinics in drugstores) after a \$25 copay
- Maternity care
- Well-child care and immunizations
- Lab tests (with Quest® Diagnostics)

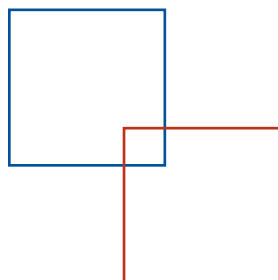
Plus, you have coverage for other doctor's office visits, hospitalizations, emergency care and surgery. You also have coverage for alternative care such as chiropractic and acupuncture. And, you can fill your generic prescriptions at a network pharmacy for a low \$10 copay.

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, pharmacy savings with the CVS Caremark ExtraCare® Health card, weight management from Weight Watchers® and identity theft protection from LifeLock®.

*These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all MHBP enrollees and their covered family members. LifeLock® is available to all FEHB enrollees 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 2012 official Plan brochure (RI 71-007). All benefits are subject to the definitions, limitations and exclusions set forth in the 2012 official Plan brochure. A single annual \$42 MHBP associate membership fee makes the Value Plan available to you.



Access our official Plan brochure at www.mhbp.com for a complete description of benefits for Value Plan.

MHBP Value Plan 2012 Benefit Summary

This is a summary of the MHBP Value Plan. DO NOT RELY ON THIS CHART ALONE. All benefits are fully described in the 2012 official Plan Brochure (RI 71-007).

MEDICAL COVERAGE	PPO Benefits (*notes calendar year deductible applies)	Non-PPO Benefits (calendar year deductible applies to all benefits)
	You pay	You pay
Preventive Care/Wellness		
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
Physician Care		
Primary Care Physician visits: Family Practice, General Practice, Internal Medicine and Pediatric	\$30 copay	40% of the Plan's allowance and any difference between our allowance and the billed amount
Specialist visits	\$50 copay*	
Convenient Care Clinic visits (such as MinuteClinic® or Take Care Clinic®)	\$25 copay	
Maternity	Nothing	
Surgery – Inpatient	20% of the Plan's allowance*	
Surgery – Outpatient (at a hospital or ambulatory surgical center)	Nothing	
Hospital/Facility Care		
Inpatient hospital (room & board and ancillary services, precertification required)	20% of the Plan's allowance*	40% of the Plan's allowance and any difference between our allowance and the billed amount
Inpatient maternity (no precertification required)	Nothing	
Outpatient hospital or ambulatory surgical facility – Surgical	\$300 copay per occurrence	
Outpatient hospital or ambulatory surgical facility – Non-surgical	20% of the Plan's allowance	
Emergency Services		
Emergency room visits	20% of the Plan's allowance per visit for the first 5 visits per person,	20% of the Plan's allowance per visit and any difference between our allowance and the billed amount for the first 5 visits per person,
	40% of the Plan's allowance per visit for all subsequent visits in a calendar year*	40% of the Plan's allowance per visit and any difference between our allowance and the billed amount for all subsequent visits in a calendar year
Urgent Care Center visits	20% of the Plan's allowance*	40% of the Plan's allowance and any difference between our allowance and the billed amount
Ambulance	20% of the Plan's allowance*	
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)	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	You pay nothing for covered lab tests with the Lab Savings Program with Quest Diagnostics®	
Alternative Treatments		
Chiropractic	20% of the Plan's allowance for up to 26 visits per person per calendar year, includes alternative, chiropractic and rehabilitative therapies combined; all charges after 26 visits.*	All charges
Acupuncture	20% of the Plan's allowance 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.
Calendar Year Deductible		
Self Only	\$600	\$900
Self and Family	\$1,200	\$1,800
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 total this amount (excludes the calendar year deductible, copayments, prescription drugs and certain other expenses).	\$7,000 (PPO providers only)	\$10,000 (includes PPO and Non-PPO providers combined)
PRESCRIPTION DRUG COVERAGE (the calendar year deductible does not apply to prescription drug benefits)		
Network Retail Pharmacy (up to a 30-day supply)		
Generic	\$10 copay	All charges
Preferred Brand**	45% of the Plan's allowance	
Non-Preferred Brand**	75% of the Plan's allowance	
Mail Order Drug Program (up to a 90-day supply)		
Generic	\$30 copay	All charges
Preferred Brand**	45% of the Plan's allowance	
Non-Preferred Brand**	75% of the Plan's allowance	
**You will pay the copayment or coinsurance amount and the difference in cost between our allowance for the generic and brand name drugs when a generic is available, unless preauthorized.		
Specialty Drugs		
Specialty drugs are used to treat chronic, complex conditions and typically require special handling and close monitoring — only available through CVS/ Caremark Specialty Pharmacy.	50% of the Plan's allowance	All charges
Prescription Drug Catastrophic Protection Out-of-Pocket Maximum		
You pay nothing for prescription drugs for the rest of the calendar year after your out-of-pocket expenses for prescription drugs obtained from a network retail pharmacy or through our mail order drug program total this amount.	\$7,000 per person	Does not apply

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 copays. Manage your health expenses and get the care you need.

MHBP Standard Option 2012 Rates	Federal Biweekly	Postal		Annuitants Monthly
		Category 1 Biweekly	Category 2 Biweekly	
Self Only – 454	\$96.34	\$75.71	\$73.13	\$208.74
Self and Family – 455	\$231.23	\$185.19	\$179.43	\$501.00

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 preventive care (e.g., annual physicals and screenings), surgery and hospitalizations, plus other valuable discounts for hearing, vision, weight management and identity theft protection.

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

- Adult annual physical exams
- 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, with no deductible:

- \$10 copay for Convenient Care Clinic visits (e.g., clinics in drugstores)
- \$20 adult office visit copay (\$10 for dependents through age 21)
- \$10 copay for generic medications at a network retail pharmacy
- \$20 copay for chiropractic visits (up to a 26-visit maximum, includes alternative and rehabilitative therapies combined)

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, pharmacy savings with the CVS Caremark ExtraCare® Health card, weight management from Weight Watchers® and identity theft protection from LifeLock®.

*These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all MHBP enrollees and their covered family members. LifeLock® is available to all FEHB enrollees 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 2012 official Plan brochure (RI 71-007). All benefits are subject to the definitions, limitations and exclusions set forth in the 2012 official Plan brochure. A single annual \$42 MHBP associate membership fee makes the Standard Option available to you.

Access our official Plan brochure at www.mhbp.com for a complete description of benefits for Standard Option.

MHBP Standard Option 2012 Benefit Summary

This is a summary of the MHBP Standard Option. DO NOT RELY ON THIS CHART ALONE. All benefits are fully described in the 2012 official Plan Brochure (RI 71-007).

MEDICAL COVERAGE	PPO Benefits (*notes calendar year deductible applies)	Non-PPO Benefits (calendar year deductible applies to all benefits, except as noted)
	You pay	You pay
Preventive Care/Wellness		
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	30% of the Plan's allowance and any difference between our allowance and the billed amount
Well-child care (routine office visits, immunizations and certain screenings)	Nothing	
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
Physician Care		
Primary Care Physician visits: Family Practice, General Practice, Internal Medicine and Pediatric	\$20 copay for adults \$10 copay for dependents through age 21	30% of the Plan's allowance and any difference between our allowance and the billed amount
Specialist visits	\$40 copay	
Convenient Care Clinic visits (such as MinuteClinic® or Take Care Clinic SM)	\$10 copay	
Maternity	Nothing	
Surgery – Inpatient	10% of the Plan's allowance*	
Surgery – Outpatient (at a hospital or ambulatory surgical center)	10% of the Plan's allowance*	
Hospital/Facility Care		
Inpatient hospital (room & board and ancillary services, precertification required)	\$200 per admission copayment and 15% of the Plan's allowance for ancillary services	\$500 copay per admission, 30% of the Plan's allowance and any difference between our allowance and the billed amount
Inpatient maternity (no precertification required)	Nothing	
Outpatient hospital or ambulatory surgical center	10% of the Plan's allowance*	30% of the Plan's allowance and any difference between our allowance and the billed amount
Emergency Services		
Emergency room visits	\$200 copay per visit for the first 5 visits per person, \$600 copay per visit for all subsequent visits in a calendar year (The calendar year deductible applies to ER visits not related to an accidental injury. Copay is waived if admitted to the hospital.)	\$200 copay per visit for the first 5 visits per person and any difference between the Plan's allowance and the billed amount, \$600 copay per visit for all subsequent visits in a calendar year and any difference between our allowance and the billed amount. (The calendar year deductible does not apply to ER visits related to an accidental injury. Copay is waived if admitted to the hospital.)
Urgent Care Center visits	\$50 copay (No deductible for accidental injury)	30% of the Plan's allowance and any difference between our allowance and the billed amount
Ambulance	10% of the Plan's allowance*	30% of the Plan's allowance and any difference between our allowance and the billed amount
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)	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	You pay nothing for covered lab tests with the Lab Savings Program with Quest Diagnostics®	
Alternative Treatments		
Chiropractic	\$20 copay per visit up to 26 visits per person per calendar year, includes alternative, chiropractic and rehabilitative therapies combined; all charges after 26 visits	30% 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. (No deductible)
Acupuncture	10% of the Plan's allowance up to 26 visits per person per calendar year, includes alternative, chiropractic and rehabilitative therapies combined; all charges after 26 visits*	30% 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.
Calendar Year Deductible		
Self Only	\$400	\$600
Self and Family	\$800	\$1,500
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 total this amount (excludes the calendar year deductible, copayments, prescription drugs and certain other expenses).	\$6,000 (PPO providers only)	\$10,000 (includes PPO and Non-PPO providers combined)
PRESCRIPTION DRUG COVERAGE (the calendar year deductible does not apply to prescription drug benefits)		
	Network Pharmacy and Electronic Claims	Non-Network Pharmacy and Paper Claims
Retail Pharmacy (up to a 30-day supply)		
Generic	\$10 copay	50% of the Plan's allowance and any difference between our allowance and the billed amount
Preferred Brand**	30% of the Plan's Allowance, limited to \$200 per prescription	
Non-Preferred Brand**	50% of the Plan's Allowance, limited to \$200 per prescription	
Mail Order Pharmacy (up to a 90-day supply)		
Generic	\$15 copay	All charges
Preferred Brand**	\$80 copay	
Non-Preferred Brand**	\$120 copay	
**You will pay the copayment or coinsurance amount and the difference in cost between our allowance for the generic and brand name drugs when a generic is available, unless preauthorized.		
Specialty Drugs		
Specialty drugs are used to treat chronic, complex conditions and typically require special handling and close monitoring – only available through CVS/ Caremark Specialty Pharmacy.	30-day supply: 15% of the Plan's allowance, limited to \$200 per prescription 90-day supply: 15% of the Plan's allowance, limited to \$425 per prescription	All charges
Catastrophic Protection Out-of-Pocket Maximum for Specialty Drugs		
You pay nothing for prescription drugs for the rest of the calendar year after your out-of-pocket expenses for these drugs total this amount.	\$5,000 per person	Does not apply

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.

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 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.

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 pay all costs 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 you pay only your copayment or coinsurance and MHBP covers the rest

The health savings account you control:

- Get up to \$845 annually (\$70.41 per month) in your HSA for Self Only coverage, or up to \$1,690 annually (\$140.83 per month) for Self and 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.

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, pharmacy savings with the CVS Caremark ExtraCare® Health card, weight management from Weight Watchers® and identity theft protection from LifeLock®.

*These benefits are neither offered nor guaranteed under contract with the FEHBP, but are made available to all MHBP enrollees and their covered family members. LifeLock® is available to all FEHB enrollees 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 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. A single annual \$42 MHBP associate membership fee makes the Consumer Option available to you.

Access our official Plan brochure at www.mhbp.com for a complete description of benefits for Consumer Option.

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, Optional: (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 (the calendar year deductible does not apply to PPO preventive care)	PPO Benefits You pay	Non-PPO Benefits You pay
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)		
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 Clinic 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 total 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)	\$7,500 Self Only (Non-PPO providers)
	\$10,000 Self & Family (PPO providers)	\$15,000 Self & Family (Non-PPO providers)
PRESCRIPTION DRUG COVERAGE (calendar year deductible applies to prescription drug benefits)	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 Dental and Vision Plans

Expand your coverage by adding one or both of our affordable options. You can enroll in these plans year round!

Call us at 1-800-254-0227 or enroll online at www.mhbp.com.

MHBP 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 42,000 VSP Choice Network provider locations nationwide
- No ID card necessary and no claim forms required
- Out-of-network benefits too

Low Monthly Vision Rates!

– \$8.60 Self

– \$16.00 Self & Family

MHBP Dental Plan

- Vast provider selection—over 120,000 dental PPO locations nationwide
- No claim forms to file—PPO dentists do it for you!
- Benefits that increase the longer you are enrolled

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%

Call today for dental rates and get your coverage started!

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A single annual \$42 MHBP associate membership fee makes the dental and/or vision plans available to you.

Frequently Asked Questions

MHBP General FAQs

Who can enroll in the MHBP?

MHBP is Open to Everyone—federal and postal employees and annuitants alike. Enroll using the method supported by your agency. For example, federal employees use Employee Express and postal employees use PostalEase.

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

No. MHBP 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 is usually required to participate in our programs. Other privileges are also available to you as an associate member, including dental and vision benefit plans and other discount programs.

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 freedom of choice and flexibility with MHBP.

Why should I choose MHBP?

The MHBP has proudly served the federal population for over 48 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 you covered where you live, work or travel nationwide. 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

MHBP Main Number

1-800-410-7778

TTY/TDD for Hearing Impaired

1-800-852-7195

Overseas Enrollees

1-480-445-5106

(For a listing of overseas toll-free numbers, visit www.mhbp.com)

Dental, Vision and Identity Theft Protection

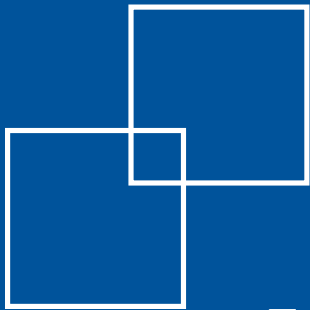
1-800-254-0227

MHBP Website

www.mhbp.com



P.O. Box 8402 • London, KY 40742



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 MHBP—a nationwide fee-for-service PPO plan that is sponsored by the National Postal Mail Handlers Union. MHBP has served federal and postal employees and annuitants for over 48 years. Our plan is open to all federal and postal employees and annuitants.