MHBP Standard Option 2017 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 official Plan Brochure (RI 71-007).		
MEDICAL COVERAGE	**Network Benefits — You Pay**	**Non-Network Benefits — 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
Women's preventive care (see official Plan Brochure for covered services)	Nothing	See Plan Brochure
Well-child care (routine office visits, immunizations and certain screenings)	Nothing	See Plan Brochure
QuitPower® tobacco cessation program (up to two quit attempts per year, with five counseling sessions per attempt)	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	$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	$30 copay	
Convenient care clinic visits (such as MinuteClinic® or Take Care Clinic℠)	$5 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 copay per admission and 10% 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
Maternity (inpatient, outpatient or birthing center)	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* (No deductible for accidental injury. Copay is waived if admitted to the hospital)	$200 copay per visit* and any difference between the Plan's allowance and the billed amount (No deductible for 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	10% of the Plan's allowance*	30% of the Plan's allowance* and any difference between our allowance and the billed amount
Specialized imaging procedures (such as CT/CAT scans, MRI and PET) Preauthorization is required *Provided in a hospital outpatient setting* *Provided in a stand-alone imaging center or clinic*	10% of the Plan's allowance* Nothing*	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 the 26-visit alternative care combined therapies annual maximum; all charges after 26 visits	30% of the Plan's allowance and any difference between our allowance and the billed amount up to the 26-visit alternative care combined therapies annual maximum; all charges after 26 visits
Acupuncture	10% of the Plan's allowance up to the 26-visit alternative care combined therapies annual maximum; all charges after 26 visits	30% of the Plan's allowance* and any difference between our allowance and the billed amount up to the 26-visit alternative care combined therapies annual maximum; all charges after 26 visits
Calendar Year Deductible — applies to all benefits marked with (*) above		
When the calendar year deductible applies, you pay these amounts before benefits begin	$350 per person, limited to $700 per Self Plus One or Self and Family enrollment	$600 per person, limited to $1,200 per Self Plus One or $1,500 Self and Family enrollment
Catastrophic Protection Out-of-Pocket Maximum		
You pay nothing for the rest of the calendar year after your out-of-pocket expenses for covered services, drugs and supplies total this amount	$6,000 per person, limited to $12,000 per Self Plus One or Self and Family enrollment	$9,000 per person, limited to $18,000 per Self Plus One or Self and Family enrollment
PRESCRIPTION DRUG COVERAGE (calendar year deductible does not apply to prescription drug benefits)	**Network Pharmacy — You Pay**	**Non-Network Pharmacy — You Pay**
Retail Pharmacy (up to a 30-day supply)		
Generic	$5 copay	$5 copay and any difference between our allowance and the billed amount
Preferred Brand †	30% of the Plan's allowance, limited to $200 per prescription	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	50% of the Plan's allowance, limited to $200 per prescription
Mail-Order Pharmacy (up to a 90-day supply)		
Generic	$10 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 a brand exception is obtained.		
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. Preauthorization is required.	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

This is a summary of the Mail Handlers Benefit Plan (MHBP) Standard Option. Before making a final decision, please read the 2017 official Plan Brochure (RI 71-007). All benefits are subject to the definitions, limitations and exclusions set forth in the official Plan Brochure. A single annual $42 associate membership fee makes all MHBP plans available to you.

2017 MHBP Standard Option Rates

Enrollment Type	Federal Biweekly	Postal Biweekly		Annuitant Monthly
		Category 1	Category 2	
Self Only – 454	$67.88	$59.06	$56.34	$147.08
Self Plus One – 456	$156.26	$135.94	$129.69	$338.56
Self and Family – 455	$157.76	$137.25	$130.94	$341.81

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