NALC Health Benefit Plan

http://www.nalc.org/**hbp**

2001

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

Sponsored and administered by the National Association of Letter Carriers (NALC), AFL-CIO

Who may enroll in this Plan: If you are a Federal or Postal employee or annuitant eligible to enroll in the FEHB Program, you may become a member of this Plan. To enroll, you must become a member of the National Association of Letter Carriers.

To become a member:

- If you are a Postal Service employee, you must pay NALC local dues.
- If you are a non-postal employee or annuitant, you become an associate member of NALC when you enroll in the NALC Health Benefit Plan.

Membership dues: NALC local dues vary by branch. NALC bills associate members $36 per year.

Enrollment codes for this Plan:

321 Self Only
322 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

Federal Employees Health Benefits Program

RI 71-9

Table of Contents

Introduction

NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149-0001

This brochure describes the benefits of the **NALC Health Benefit Plan** under our contract (CS 1067) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page **55**. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means NALC Health Benefit Plan.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure, and e-mail OPM at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

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

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

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

We also have Preferred Provider Organizations (PPO)

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you receive covered services at reduced cost. Contact us for the names of PPO providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory.

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

How we pay providers

When you use a PPO provider or facility, our Plan allowance is the negotiated rate for the service. You are not responsible for charges above the negotiated amount.

Non-PPO facilities and providers do not have special agreements with the Plan. Our payment is based on the Plan allowance for covered services. You may be responsible for amounts over the allowance.

We also obtain discounts from some non-PPO providers. When we obtain discounts through negotiation with providers (PPO or non-PPO), we pass along the savings to you.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- The NALC Health Benefit Plan has been part of the FEHB since July 1960.
- We are a not-for-profit employee organization sponsored health plan.
- Our preferred provider organization (PPO) is The **First Health**®, Network.
- Our network provider for mental health and substance abuse benefits is United Behavioral Health.
- Our prescription drug retail network is NALC CareSelect Network pharmacy.
- Our mail order prescription program is through CAREMARK.

If you want more information about us, call 703/729-4677 or 888/636-NALC, or write to NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149-0001. You may also visit our website at www.nalc.org/hbp.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our PPO network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing and day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 703/729-4677 or 888/636-NALC (6252), **or** checking our website www.nalc.org/hbp. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.
- North Dakota is deleted from the list of states designated as medically underserved in 2001. See page 6 for information on medically underserved areas.

Changes to this Plan

- Your share of the NALC Postal premium will increase by 2.3% for Self Only and decrease by 3.8% for Self and Family.
- Your share of the NALC non-Postal premium will increase by 4.6% for Self Only or 1.4% for Self and Family.
- We lowered your coinsurance from 15% to 10% for surgery by a PPO provider.
- We increased your 100% coverage for accidental injury from 48 hours to 72 hours.
- You no longer have to pay the $25 drug deductible when you purchase prescription drugs using your identification card at an NALC CareSelect retail pharmacy.
- You can now purchase a 60-day supply of prescription drugs at a copayment of $8 generic/$17 name brand through our mail order program, for those times you do not need a 90-day supply.
- If you have Medicare, your mail order copayment is $5 generic/$13 name brand for a 60-day supply, or $7.50 generic/$19.50 name brand for a 90-day supply, instead of $2 generic/$4 name brand for a 90-day supply.
- When you purchase prescription drugs using your identification card at an NALC CareSelect network pharmacy, you pay 25% of the discounted drug rate, instead of the $5 generic/$10 name brand copayments. If you have Medicare, you pay 15% of the discounted drug rate, instead of the $1 generic/$2 name brand copayments.
- For a PPO office visit, your copayment is $20 instead of $15.
- We lowered your calendar year deductible from $275 to $250 per person ($550 to $500 family) for services of a PPO provider.
- We increased your calendar year deductible from $275 to $300 per person ($550 to $600 family) for services by a non-PPO provider. Whether you use PPO or non-PPO providers, your deductible will not exceed $300 per person ($600 family).
- We increased your calendar year deductible from $250 to $300 per person for services of an out-of-network mental health provider.
- We increased your calendar year deductible from $250 to $300 per person for an inpatient admission in an out-of-network treatment facility for substance abuse.
- Coverage in a skilled nursing facility is limited to enrollees with Medicare Part A primary. Previously, skilled nursing facility benefits were available to all enrollees.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a provider or fill a prescription at an NALC CareSelect retail pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter. If you want to obtain a prescription at an NALC CareSelect retail pharmacy and have not received your identification card, contact us at 703/729-4677 or 888/636-NALC (6252).

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 703/729-4677 or 888/636-NALC (6252).

Where you get covered care

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

- **Covered providers**

We consider the following to be covered providers when they perform services within the scope of their license or certification:

- A licensed doctor of medicine (M.D.) or osteopathy (D.O.); or, for specified services covered by the Plan, a licensed dentist (D.D.S. or D.M.D.), or podiatrist (D.P.M.).
- A nurse anesthetist (C.R.N.A.).
- A community mental health organization: A nonprofit organization or agency with a governing or advisory board representative of the community that provides comprehensive, consultative and emergency services for treatment of mental conditions.
- A qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist, and nursing-school-administered clinic. The term "physician" includes all of these providers when they perform services within the scope of their license or certification.
- Other providers listed in Section 5. *Benefits*.

Medically underserved areas. In medically underserved areas, we cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2001, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Utah, and Wyoming.

- **Covered facilities**

Covered facilities include:

Birthing center

A freestanding facility that provides comprehensive maternity care in a home-like atmosphere and is licensed or certified by the jurisdiction.

Hospice

A facility that 1) provides care to the terminally ill; 2) is licensed or certified by the jurisdiction in which it operates; 3) is supervised by a staff of physicians (M.D. or D.O.) with at least one such physician on call 24 hours a day; 4) provides 24-hour-a-day nursing services under the direction of a registered nurse (R.N.) and has a full-time administrator; and 5) provides an ongoing quality assurance program.

Hospital

1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or 2) any other institution licensed as a hospital, operating under the supervision of a staff of physicians with 24-hour-a-day registered nursing service, and is primarily engaged in providing general inpatient acute care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities. All these facilities must be provided on its premises or under its control.

The term "hospital" does not include a convalescent home or extended care facility, or any institution or part thereof which a) is used principally as a convalescent facility, nursing home, or facility for the aged; b) furnishes primarily domiciliary

or custodial care, including training in the routines of daily living; or c) is operated as a school or residential treatment facility.

Skilled nursing facility (SNF)

A facility eligible for Medicare payment, or a government facility not covered by Medicare, that provides continuous non-custodial inpatient skilled nursing care by a medical staff for post-hospital patients.

Treatment facility

A freestanding facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for treatment of substance abuse.

What you must do to get covered care

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

- **Transitional care**

Specialty care. If you have a chronic or disabling condition and lose access to your specialist because we:

- Terminate our contract with your specialist for other than cause; or
- Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us if you think you are eligible.

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

Hospital care. We pay for covered services from the effective date of your enrollment. If you are in the hospital, however, when your enrollment in our Plan begins, call our customer service department immediately at 703/729-4677 or 888/636-NALC (6252)**.**

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

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

These provisions apply only to the benefits of the hospitalized person.

How to Get Approval for…

- **Your hospital stay**

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

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

Warning:

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

How to precertify an admission:

- You, your representative, your physician, or your hospital must call us at 800/622-6252 prior to admission, unless your admission is related to a mental health and substance abuse condition. In that case call 877/468-1016.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you**,** your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Member identification number;
  - Patient's name, birth date, and phone number;

continues on next page

- Reason for hospitalization, and proposed treatment or surgery;
- Name and phone number of admitting physician;
- Name of hospital or facility; and
- Number of planned days of confinement.

- We will tell the physician and/or hospital the number of approved inpatient days and send written confirmation of our decision to you, your physician**,** and the hospital.

Maternity care

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us within two business days for precertification of additional days for your baby.

If your hospital stay needs to be extended:

If your hospital stay — including for maternity care — needs to be extended, your physician or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

- When we have precertified the admission but you remain in the hospital beyond the number of days we approved, and you do not get the additional days precertified, then:
  - for any part of the admission that we determine was medically necessary, we pay inpatient benefits, but
  - for the part of the admission that we determine was not medically necessary, we pay only for medical services and supplies otherwise payable on an outpatient basis and do not pay inpatient benefits.
- If no one contacted us, we decide whether the hospital stay was medically necessary.
  - If we determine that the stay was medically necessary, we pay the inpatient charges, but reduce benefits by $500.
  - If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will pay only for covered medical supplies and services that would be otherwise payable on an outpatient basis.
- If we denied the precertification request, we will not pay inpatient hospital benefits. We pay only for covered medical supplies and services that would be otherwise payable on an outpatient basis.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance — including Medicare Part A — that is the primary payer for the hospital stay.

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we become the primary payer and you do need precertification.

• Other services

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

- Growth hormone therapy (GHT): We cover GHT only when we preauthorize the treatment. Call 800/433-NALC (6252) for preauthorization. See Section 5(a). *Treatment therapies.*
- Some drugs, such as those for sexual dysfunction, require prior authorization. Call us at 800/433-NALC (6252) for information.
- Organ/tissue transplants and donor expenses: The Plan participates in the **First Health** National Transplant Program. Before your initial evaluation as a potential candidate for a transplant procedure, you or your physician must contact **First Health** at 800/622-6252 and speak to a Transplant Case Manager. See Section 5(b). *Organ/tissue transplants*.
- Mental health and substance abuse care: United Behavioral Health (UBH) provides the Plan's mental health and substance abuse benefits. Call 877/468-1016 for preauthorization. See Section 5(e). *Mental health and substance abuse benefits*.
- Durable medical equipment (DME): Although DME does not require prior authorization, you should call us at 800/433-NALC (6252) before you purchase or rent DME so we can give you information on discounted rates. See Section 5(a). *Durable medical equipment*.

Section 4. Your costs for covered services

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

- **Copayments**

  A copayment is a fixed amount of money you pay to the provider when you receive services. Copayments are not the same for all services. See Section 5. *Benefits*.

  Example: When you see your PPO physician you pay a $20 copayment per office visit.

- **Deductible**

  A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those expenses. The family deductible is satisfied when the combined covered expenses applied to the calendar year deductible for family members total the amounts shown. Copayments do not count toward any deductible.

  - The PPO calendar year deductible is $250 per person ($500 per family). If you use non-PPO providers, your calendar year deductible is increased to a maximum of $300 per person ($600 per family). Whether or not you use PPO providers your deductible will not exceed $300 per person ($600 per family).
  - The calendar year drug deductible of $25 per person or $50 per family applies only to non-network benefits.
  - The calendar year deductible for in-network mental health and substance abuse benefits is $250 per person ($500 per family).
  - The calendar year deductible for out-of-network mental health and substance abuse inpatient and outpatient professional services is $300 per person ($600 per family).
  - The calendar year deductible for out-of-network substance abuse treatment in a treatment facility is $300 per person.

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

- **Coinsurance**

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

  Example: When you see a non-PPO physician, your coinsurance is 30% of our allowance for office visits.

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

  For example, if your physician ordinarily charges $100 for a service but routinely waives your 30% coinsurance, the actual charge is $70. We pay $49 (70% of the actual charge of $70).

- **Differences between our allowance and the bill**

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

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

  - **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your copayment, deductible, and coinsurance. Here is an example: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 15% of our $100 allowance ($15). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his/her bill.

continues on next page

- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you pay your copayment, deductible, and coinsurance, **plus** any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the non-PPO physician and us, he/she can bill you for the $50 difference between our allowance and his/her bill.

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

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	$150	$150
Our allowance	We set it at: 100	We set it at: 100
We pay	85% of our allowance: 85	70% of our allowance: 70
You owe Coinsurance	15% of our allowance: 15	30% of our allowance: 30
+Difference up to charge	No: 0	Yes: 50
TOTAL YOU PAY	$15	$80

Your out-of-pocket maximum for coinsurance

For those services with coinsurance (excluding mental health and substance abuse care), we pay 100% of the Plan allowance for the remainder of the calendar year after your coinsurance expenses total these amounts:

- $3000 for services of PPO providers/facilities
- $3500 for services of PPO and non-PPO providers/facilities, combined

For mental health and substance abuse benefits, we pay 100% of the Plan allowance for the remainder of the calendar year after your coinsurance expenses total these amounts:

- $3000 for services of network mental health and substance abuse providers/facilities
- $8000 for out-of-network mental health and substance abuse inpatient hospital treatment (to a maximum of 50 days)

Note: Your out-of-pocket maximum does not apply to these benefits:

- Skilled nursing care
- Prescription drugs
- Any out-of-network outpatient mental health and substance abuse professional care

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

- Deductibles
- Copayments
- Expenses incurred under Prescription Drug Benefits
- Expenses in excess of the Plan allowance or maximum benefit limitations
- Any out-of-network expenses for mental health and substance abuse professional care, except inpatient hospital stays
- Amounts you pay for non-compliance with this Plan's cost containment requirements
- Coinsurance for skilled nursing care

When government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

If we overpay you

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

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

Under the FEHB law, we must limit our payments for those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. The following chart has more information about the limits.

If you…

- are age 65 or older, and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care in a Medicare participating hospital,

- The law requires us to base our payment on an amount — the "equivalent Medicare amount" — set by Medicare's rules for what Medicare would pay, not on the actual charge;
- You are responsible for your coinsurance and any applicable deductibles or copayments you owe under this Plan;
- You are not responsible for any charges greater than the equivalent Medicare amount; we show that amount on the explanation of benefits; and
- The law prohibits a hospital from collecting more than the Medicare equivalent amount.

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

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

If your physician…	Then you are responsible for…
Participates with Medicare or accepts Medicare assignment for the claim	your deductibles, coinsurance, and copayments;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

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

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

continues on next page

When you have the Original Medicare Plan

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

When you are covered by Medicare Part B and it is primary, you pay no out-of-pocket expenses for services both we and Medicare Part B cover.

- If your physician accepts Medicare assignment, then you pay nothing for covered charges.
- If your physician does not accept Medicare assignment, then you pay nothing for covered charges because we include payment up to the limiting charge.

Note: The physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) that Medicare will send you will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask them to reduce their charges. If they do not, report them to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

When you have a Medicare Private Contract

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

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

Section 5. Benefits — OVERVIEW

(See page 5 for how our benefits changed this year and page 55 for a benefits summary.)

NOTE: This Benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 703/729-4677 or 888/636-NALC (6252).

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The PPO calendar year deductible is $250 per person ($500 per family). If you use non-PPO providers your calendar year deductible is $300 per person ($600 per family). Whether you use PPO or non-PPO providers, your deductible will not exceed $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Please keep in mind that when you use a PPO hospital, the professionals who provide services to you in the hospital, such as emergency room physicians, radiologists, anesthetists and pathologists, may **not** all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- Be sure to read Section 4. *Your costs for covered services* for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage*.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • Office or outpatient visits	PPO: $20 copayment per office visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Professional services of physicians • Hospital care • Skilled nursing facility care • Initial examination of a newborn child covered under a family enrollment • Medical consultations • Second surgical opinions • Home visits Note: For routine post-operative surgical care, see Section 5(b). *Surgical procedures*.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Routine physical checkups and related tests* • *Routine eye and hearing examinations* • *Services by chiropractors, except in those states designated as medically underserved areas* • *Nonsurgical treatment for weight reduction or obesity*	*All charges*

Lab, X-ray and other diagnostic tests	You pay
Tests and their interpretation, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram (EKG) • Electroencephalogram (EEG)	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount Note: When tests are performed during an inpatient confinement no deductible applies.
Not covered: Routine tests, except listed under Preventive care, adult	*All charges*
Plan pays for pre-admission testing within 7 days of admission or outpatient surgery. Screening tests, limited to: • Chest X-rays • Electrocardiograms • Urinalysis • Blood work *Note: Diagnostic tests, such as magnetic resonance imaging, throat cultures or similar studies are not considered as preadmission testing.*	PPO: Nothing (No deductible) Non-PPO: 20% of the Plan allowance (No deductible), and the difference, if any, between our allowance and the billed amount
Preventive care, adult	
Routine screenings, limited to: • Blood lead level – one annually • Total blood cholesterol – one every three years, ages 19 through 64 • Colorectal cancer screening, including •• Fecal occult blood test — one annually, age 40 and older	PPO: $5 copayment (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
•• Routine Sigmoidoscopy, screening – one every five years, age 50 and older	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between the Plan allowance and the billed amount
• Routine Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	PPO: $25 copayment (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Routine pap test Note: We cover the office visit if it is on the same day as the pap test. See *Diagnostic and treatment services* in this section.	PPO: Nothing for first $35 in charges (No deductible), then 15% of the Plan allowance Non-PPO: Nothing for first $35 in charges (No deductible), then 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Routine mammogram – for women age 35 and older, as follows: •• Ages 35 through 39, one during this five year period •• Ages 40 through 64, one every calendar year •• Age 65 and older, one every two consecutive calendar years	PPO: $25 copayment (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – one every 10 years, age 19 and older (except as provided for under *Preventive care, children*) • Influenza/Pneumococcal vaccines, one annually, age 65 and older	PPO: $5 copayment (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics, ages 3 through 21	PPO: Nothing (No deductible) Non-PPO: The difference, if any, between our allowance and the billed amount (No deductible)
• Well-child care—routine examinations and immunizations, through age 2 Note: For the coverage of the initial newborn exam see *Diagnostic and treatment services* in this section.	PPO: Nothing (No deductible) Non-PPO: The difference, if any, between our allowance and the billed amount (No deductible)
• Examinations, limited to: •• Examinations for amblyopia (lazy eye) and strabismus (crossed eyes) – limited to one screening examination, ages 2 through 6	PPO: $15 copayment (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Examinations done on the day of immunizations, ages 3 through 21	PPO: $20 copayment per office visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Amniocentesis	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Group B streptococcus infection screening • Sonograms • Fetal monitoring • Other tests medically indicated for the unborn child Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see Section 3 *How to get approval for…* for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c). *Inpatient hospital* and Section 5(b). *Surgical procedures.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*

Family planning	You pay
Surgical procedures for: • Voluntary sterilization • Implanted contraceptives • Intrauterine devices (IUDs)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Injectable contraceptive drugs Note: For other contraceptive drugs, see Section 5(f). *Prescription drug benefits*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: reversal of voluntary surgical sterilization, and genetic counseling	*All charges*
Infertility services	
Diagnosis and treatment of infertility, except as listed in *Not covered*. Note: For surgical services see Section 5(b).	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference if any between our allowance and the billed amount

Not covered:
• *Assisted reproductive technology (ART) procedures, such as:*
  •• *Artificial insemination*
  •• *In vitro fertilization*
  •• *Embryo transfer and gamete intrafallopian tube transfer (GIFT)*
• *Services and supplies related to ART procedures*
	All charges

Allergy care	
• Testing • Treatment, except for allergy injections • Allergy serum	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Allergy injections	PPO: $5 copayment each (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Provocative food testing and sublingual allergy desensitization* • *Environmental control units, such as air conditioners, purifiers, humidifiers, and dehumidifiers*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b) *Organ/tissue transplants*. • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Respiratory and inhalation therapies • Growth hormone therapy (GHT) Note: We cover GHT only when we preauthorize the treatment. Call 800/433-NALC (6252) for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will cover GHT services only from the date you submit the information. If you do not ask, or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Treatment therapies – Continued on next page

Treatment therapies – *Continued*	**You pay**
Not covered: Chelation therapy, except as treatment for acute arsenic, gold, lead or mercury poisoning	*All charges*
Rehabilitative therapies	
Physical therapy, occupational therapy, and speech therapy • Up to 90 visits per calendar year for the services of each of the following: •• Qualified physical therapists; •• Speech therapists; and •• Occupational therapists. Note: We cover therapy only to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury and when the attending physician: • Orders the care; • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Maintenance therapy, including cardiac rehabilitation and exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing testing for covered diagnoses, such as otitis media and mastoiditis • First hearing aid and examination, limited to services necessitated by accidental injury	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Routine hearing testing* • *Hearing aid and examination, except when necessitated by accidental injury*	*All charges*
Vision services (testing, treatment, and supplies)	
• Eye examinations for covered diagnoses, such as cataract and glaucoma	PPO: $20 copayment per office visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: For examinations for amblyopia and strabismus, see *Preventive care, children.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Refractions*	*All charges*

Foot care	You pay
Nonsurgical routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Surgical procedures for routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes • Open cutting, such as the removal of bunions or bone spurs	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotics, arch supports, heel pads and cups* • *Orthopedic and corrective shoes*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Custom-made durable braces for legs, arms, neck and back • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy Note: Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy are paid as hospital benefits; see Section 5(c), *Inpatient hospital*. Insertion of the device is paid as surgery; see Section 5(b) *Surgical procedures*.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics (shoe inserts)* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacement provided less than 3 years after the last one we covered*	*All charges*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that are: • Prescribed by your attending physician (i.e., the physician who is treating your illness or injury); • Medically necessary; • Primarily and customarily used only for a medical purpose; • Generally useful only to a person with an illness or injury; • Designed for prolonged use; and • Intended to serve a specific therapeutic purpose in the treatment of an illness or injury.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Durable medical equipment (DME) – Continued on next page

Durable medical equipment (DME) – *Continued*	**You pay**
Note: Call us at 800/433-NALC (6252) as soon as your physician prescribes equipment or supplies. We have arranged with a health care provider to rent or sell durable medical equipment at discounted rates and will tell you more about this service when you call. We cover rental or purchase (at our option) including repair and adjustment of durable medical equipment: • Oxygen and oxygen apparatus • Dialysis appliances We also cover supplies, such as: • Hospital beds • Wheelchairs • Crutches, canes, and walkers • Insulin and diabetic supplies • Needles and syringes for covered injectables • Ostomy and catheter supplies • Home IV and antibiotic therapy	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *DME replacements provided less than 3 years after the last one we covered* • *Sun or heat lamps, whirlpool baths, saunas and similar household equipment* • *Safety, convenience and exercise equipment* • *Communication equipment including computer "story boards" or "light talkers"* • *Enhanced vision systems, computer switch boards or environmental control units* • *Heating pads, air conditioners, purifiers and humidifiers* • *Stair climbing equipment, stair glides, ramps, elevators* • *Modifications or alterations to vehicles or households* • *Other items (such as wigs) that do not meet the definition of DME. See Section 10.* Definitions.	*All charges*
Home health services	
Up to 90 days per calendar year (with a maximum Plan payment of $75 per day) when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed.	PPO: 20% of the Plan allowance (No deductible) plus all charges after we pay $75 per day Non-PPO: 20% of the Plan allowance (No deductible) plus all charges after we pay $75 per day
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication*	*All charges*

Alternative treatments	You pay
Acupuncture, limited to treatment by a doctor of medicine or osteopathy for pain relief	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Chiropractic services and related tests* • *Naturopathic services* Note: In medically underserved areas, we may cover services of alternative treatment providers; see Section 3 *Covered providers*.	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – One smoking cessation program per member per lifetime, up to a maximum Plan payment of $100 including all related expenses such as drugs	PPO: Nothing for the first $100 Non-PPO: Nothing for the first $100

• Diabetes training for self-management when:
  • Prescribed by the attending physician; and
  • Administered by a covered provider, such as a registered nurse.
	PPO: 15% of the Plan allowance
	Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The PPO calendar year deductible is $250 per person ($500 per family). If you use non-PPO providers your calendar year deductible is $300 per person ($600 per family). Whether you use PPO or non-PPO providers, your deductible will not exceed $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4. *Your costs for covered services* for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage*.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Please keep in mind that when you use a PPO hospital, the professionals who provide services to you in the hospital, such as emergency room physicians, radiologists, anesthetists and pathologists, may **not** all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical procedure, including normal pre- and post-operative care. Look in Section 5 (c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRIOR AUTHORIZATION FOR ORGAN/TISSUE TRANSPLANTS. See Section 5(b) *Organ/tissue transplants*.**

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Surgical procedures	
Surgeons' charges for procedures, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care • Correction of amblyopia and strabismus • Endoscopy • Biopsy • Removal of tumors and cysts • Correction of congenital anomalies • Gastric bypass or stapling for treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight with complicating medical conditions and attempts to reduce weight using a doctor-monitored diet and exercise program were unsuccessful; eligible members must be age 18 or older. • Insertion of internal prosthetic devices	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Surgical procedures - Continued on next page

Surgical procedures – *Continued*	**You pay**
• Voluntary sterilization, surgically implanted contraceptives and intrauterine devices (IUDs) • Debridement of burns Note: When multiple or bilateral surgical procedures are performed during the same operative session, the Plan allowance is increased if the additional procedure adds complexity to the operative session. The increase is one-half of what the Plan allowance would have been if that procedure had been performed independently. The Plan allowance for an assistant surgeon will not exceed 25% of our allowance for the surgeon.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our payment and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone)* • *Cosmetic surgery, except for repair of accidental injury if repair is initiated within six months after an accident; for correction of a congenital anomaly; and for breast reconstruction following a mastectomy* • *Radial keratotomy and other refractive surgery* • *Procedures performed through the same incision deemed incidental to the total surgery, such as appendectomy, lysis of adhesion, puncture of ovarian cyst* • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as listed under Section 5(a) Foot care*	*All charges*
Reconstructive surgery	

• Surgery to correct a functional defect
• Surgery to correct a condition caused by injury or illness if:
  •• The condition produced a major effect on the member's appearance; and
  •• The condition can reasonably be expected to be corrected by such surgery
• Surgery to correct a congenital anomaly (condition that existed at or from birth and is a significant deviation from the common form or norm). Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes.
• All stages of breast reconstruction surgery following a mastectomy, such as:
  •• Surgery to produce a symmetrical appearance on the other breast
  •• Treatment of any physical complications, such as lymphedemas
 	
Note: Congenital anomaly does not include conditions related to teeth or intra-oral structures supporting the teeth.
 	
Note: We cover internal and external breast prostheses, surgical bras and replacements. See Section 5(a) *Orthopedic and prosthetic devices* and Section 5(c) *Inpatient hospital*.
 	
Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
	PPO: 10% of the Plan allowance
	
	Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Reconstuctive surgery – Continued on next page

Reconstructive surgery – *Continued*	**You pay**
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated within six months* • *Injections of silicone, collagens and similar substances* • *Surgeries related to sex transformation or sexual dysfunction*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Treatment of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
Limited to: • Bone • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver • Lung: Single – only for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension, or emphysema; Double – only for patients with cystic fibrosis • Pancreas • Allogenic bone marrow transplants, limited to patients with acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, aplastic anemia, chronic myelogenous leukemia, infantile malignant osteoporosis, severe combined immunodeficiency, thalassemia major, or Wiskott-Aldrich syndrome • Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for acute lymphocytic or non-lymphomcytic leukemia; advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal retroperitoneal and ovarian germ cell tumors	Nothing, for services obtained through the National Transplant Program (NTP). (No deductible) PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Organ/tissue transplants – Continued on next page

Organ/tissue transplants – *Continued*	**You pay**
National Transplant Program (NTP) – The Plan participates in The **First Health**, National Transplant Program. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact First Health at 800/622-6252 and speak to a Transplant Case Manager. You will be given information about this program including a list of participating providers. Charges for services performed by a National Transplant Program provider, whether incurred by the recipient or donor are paid at 100%. Participants in the program must receive prior approval from the Plan for travel and lodging expenses. Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.	Nothing, for services obtained through the National Transplant Program (NTP). (No deductible) PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Note: Limited Benefits – If you do not obtain prior approval or do not use a designated facility, we pay a maximum of $100,000 for each listed transplant (kidney limit, $50,000), for these combined expenses: pre-transplant evaluation; organ procurement; and inpatient hospital, surgical and medical expenses. We pay benefits according to the appropriate benefit section, such as Section 5(c) *Inpatient hospital* and *Surgical procedures*. The limitation applies to expenses incurred by either the recipient or donor.	
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Travel and lodging expenses, except when approved by the Plan* • *Implants of artificial organs* • *Transplants and related services and supplies not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient)	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (No deductible)
Professional services provided in: • Hospital outpatient department • Ambulatory surgical center • Office • Other outpatient facility	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The PPO calendar year deductible is $250 per person ($500 per family). If you use non-PPO providers your calendar year deductible is $300 per person ($600 per family). Whether you use PPO or non-PPO providers, your deductible will not exceed $300 per person ($600 per family). Unlike Sections (a) and (b), in this section, the calendar year deductible applies to only a few benefits. In that case, we say "calendar year deducible applies".
- Be sure to read Section 4.*Your costs for covered services* for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage*.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Please keep in mind that when you use a PPO hospital, the professionals who provide services to you in the hospital, such as emergency room physicians, radiologists, anesthetists and pathologists, may **not** all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- The amounts listed below are for charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Look in Section 5(a) or (b) for costs associated with the professional charge (i.e. physicians, etc.).
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
NOTE: The calendar year deductible applies ONLY when we say below: "calendar year deductible applies".	
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: We cover a private room only when you must be isolated to prevent contagion. Otherwise, we pay the hospital's average charge for semiprivate accommodations. If the hospital has private rooms only, we base our payment on the average semiprivate rate of the most comparable hospital in the area. Note: When the non-PPO hospital bills a flat rate, we prorate the charge as follows: 30% room and board and 70% other charges.	PPO: Nothing Non-PPO: $100 copayment per admission and 20% of the Plan allowance

Inpatient hospital – Continued on next page

Inpatient hospital – *Continued*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Pre-admission testing (within 7 days of admission) • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Internal prostheses • Professional ambulance service to the nearest hospital equipped to handle your condition Note: We base payment on who bills for the services or supplies. For example, when the hospital bills for its nurse anesthetist's services, we pay hospital benefits (*Inpatient hospital)* and when the anesthesiologist bills, we pay anesthesia benefits (see Section 5(b) *Surgical procedures*). Note: We cover your admission for dental procedures only when you have a nondental physical impairment that makes admission necessary to safeguard your health. We do not cover the dental procedures. Note: We cover admission for inpatient foot treatment even if no other benefits are payable.	PPO: Nothing Non-PPO: $100 copayment per admission and 20% of the Plan allowance
Take-home items • Medical supplies, appliances, and equipment; and any covered items billed by a hospital for use at home	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance (calendar year deductible applies)
Not covered: • *Any part of a hospital admission that is not medically necessary (see Section 10.* Definitions . . . Medically necessary*), such as long term care or when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see Section 10.* Definitions . . . Custodial care • *Non-covered facilities, such as nursing homes, extended care facilities, and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
Services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, casts, splints, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non dental physical impairment. We do not cover the dental procedures.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Not covered: personal comfort items	*All charges*
Skilled nursing care facility benefits	
Limited to care in a skilled nursing facility (SNF) when your Medicare Part A is primary. We cover semiprivate room, board, services and supplies in a SNF for up to 30 days per confinement when: • You are admitted directly from a precertified hospital stay of at least 3 consecutive days; • You are admitted for the same condition as the hospital stay; • Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and • SNF care is medically necessary.	PPO: Nothing Non-PPO: The difference, if any, between our allowance and the billed amount
Not covered: custodial care	*All charges*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. Limited benefits: We pay up to $3000 per lifetime for a combination of inpatient and outpatient services.	PPO: 15% of the Plan allowance, and all charges after we pay $3000 (calendar year deductible applies) Non-PPO: 30% of the Plan allowance, and all charges after we pay $3000 (calendar year deductible applies)
Not covered: • *Private nursing care* • *Homemaker services* • *Bereavement services*	*All charges*
Ambulance	
Local professional ambulance service when medically necessary	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Not covered: transportation (other than professional ambulance services), such as by ambulette or medicab	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The PPO calendar year deductible is $250 per person ($500 per family). If you use non-PPO providers your calendar year deductible is $300 per person ($600 per family). Whether you use PPO or non-PPO providers, your deductible will not exceed $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Please keep in mind that when you use a PPO hospital, the professionals who provide services to you in the hospital, such as emergency room physicians, radiologists, anesthetists and pathologists, may **not** all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage*.

IMPORTANT

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external and accidental means. We do not cover dental care for accidental injury.

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Accidental injury	
If you receive the care within 72 hours after your accidental injury, we cover: • Nonsurgical services and supplies by a physician • Related nonsurgical outpatient hospital services and supplies • Local professional ambulance service when medically necessary	PPO: Nothing (No deductible) Non-PPO: The difference, if any, between our allowance and the billed amount (No deductible)
If you receive care for your accidental injury after 72 hours, we cover: • Outpatient hospital and physician services and supplies not related to surgical procedures Note: For surgery related to an accidental injury, see Section 5(b) *Surgical procedures.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount

Medical emergency	
Outpatient medical services and supplies. See Section 5(a) *Medical services and supplies.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Surgical services. See Section 5(b) *Surgical procedures.*	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Ambulance	
Local professional ambulance service when medically necessary, not related to an accidental injury	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: transportation (other than professional ambulance services), such as by ambulette or medicab	*All charges*

Section 5 (e). Mental health and substance abuse benefits

In-Network Benefits

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

You may now choose to get care Out-of-Network (same as before) or **In-Network** (new in 2001). When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- There is a separate calendar year deductible for In-Network mental health and substance abuse of $250 per person ($500 per family). This calendar year deductible applies to almost all benefits in this Section. We say "No deductible" to show when the calendar year deductible does not apply.
- When no In-Network provider is available, Out-of-Network benefits will be paid.
- Be sure to read Section 4. *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 33.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
In-Network benefits	
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost-sharing responsibilities are no greater than for other illness or conditions, such as $20 copayment per office visit, or 15% of the Plan allowance for other outpatient services after the calendar year deductible is met.
• Outpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Outpatient medication management	$20 copayment per office visit (No deductible)
• Outpatient diagnostic tests	15% of the Plan allowance

In-Network benefits — Continued on next page.

In-Network benefits – *Continued*	**You pay**
• Inpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers	15% of the Plan allowance
• Inpatient services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing (No deductible)
Not covered: • *Services we have not approved* • *Treatment for learning disabilities and mental retardation* • *Treatment for marital discord* Note: Exclusions that apply to other benefits apply to these mental health and substance abuse benefits, unless the services are included in a treatment plan that we approve. Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	*All charges*

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and the following network authorization process:

United Behavioral Health provides our mental health and substance abuse benefits. Call 877/468-1016 to locate network clinicians who can best meet your needs, and to receive authorization to see a provider. You and your provider will receive written confirmation of the authorization from United Behavioral Health for the initial and any ongoing authorizations.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause, or
- If changes to this plan's benefit structure for 2001 cause your out-of-pocket costs for your out-of-network provider to be greater than they were in year 2000.

If these conditions apply to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

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

Out-of-Network Benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible for inpatient and outpatient professional services is $300 per person. The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" to show when the calendar year deductible does not apply.
- The calendar year deductible in a treatment facility is $300 per person.
- Be sure to read Section 4. *Your costs for covered services* for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage.*
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Out-of-Network benefits	
Inpatient and outpatient professional services of providers, such as psychiatrists, psychologists, clinical social workers, or community mental health organizations: Up to 30 visits per calendar year for diagnostic tests; office, outpatient, and hospital visits	$300 mental conditions/substance abuse calendar year deductible, then 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount; all charges after 30 visits
Up to 50 days per calendar year for inpatient hospital charges: • Ward or semiprivate accommodations • All other charges	$500 copayment per admission plus 50% of the Plan allowance (No deductible); all charges after 50 days
Up to 30 days per lifetime for services in a treatment facility for rehabilitative substance abuse care: • Ward or semiprivate accommodations • All other charges	$300 treatment facility calendar year deductible, then 50% of the Plan allowance; all charges after 30 days
Not covered: • Services by pastoral, marital, drug/alcohol, and other counselors • Treatment for learning disabilities and mental retardation • Treatment for marital discord • Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staffs Note: Exclusions that apply to other benefits apply to these mental health and substance abuse benefits, unless the services are included in a treatment plan that we approve.	*All charges*

Lifetime maximum Out-of-Network inpatient care for the treatment of alcoholism and drug abuse is limited to a 30-day lifetime benefit.

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

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

- Section 4. *Your cost for covered services*, and your out-of-pocket maximum for coinsurance.
- Section 7. *Filing a claim for covered services*, for information about submitting Out-of-Network claims.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed medications and supplies as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year drug deductible of $25 per person or $50 per family applies only to non-network benefits. We say "No deductible" to show when the calendar year drug deductible does not apply.
- Some drugs require prior authorization. Call the Plan at 800/433-NALC for information.
- Maximum dosage dispensed may be limited by protocols established by the Plan.
- When we say "Medicare" in this section we mean you have Medicare Part B and it is primary.
- Be sure to read Section 4. *Your costs for covered services* for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage*.

IMPORTANT

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy.
  - **Network pharmacy –** Present your Plan identification card at an NALC CareSelect Network pharmacy to purchase prescription drugs. Call 800/933-NALC to locate the nearest network pharmacy.
  - **Non-network pharmacy** – You may purchase prescriptions at pharmacies that are not part of our network. You pay full cost and must file a claim for reimbursement. See *When you have to file a claim.*
  - **Mail order** – Complete the NALC mail order form/patient profile with your first order. Send this form, along with your prescription(s) and payment, in the preaddressed envelope to:

    NALC Prescription Drug Program
    P.O. Box 380
    Lincolnshire, IL 60069-0380
- **We use an open formulary.** If your physician believes a name brand product is necessary, or there is no generic available, your physician may prescribe a name brand drug from our formulary list. These preferred name brand drugs are selected to meet patient needs at lower cost. To order the Formulary pamphlet, call 800/933-NALC.
- **These are the dispensing limitations.**
  - Network retail pharmacy – You may obtain up to a 30-day supply plus one refill for each prescription. No deductible applies. After one refill, you must obtain a new prescription and submit it to the mail order program. Failure to do so results in benefits payable at the non-network retail pharmacy benefit level (which includes a deductible), and you will need to file a claim for reimbursement.
  - Non-network retail pharmacy – You may obtain up to a 30-day supply and unlimited refills for each prescription. You will need to file a claim for reimbursement.
  - Mail order – You may order up to a 60-day or 90-day (21-day minimum) supply of medication for each prescription or refill. No deductible applies. You cannot obtain a refill until 75% of the drug has been used. Medications dispensed through the mail order program are subject to the following standards: the professional judgment of the pharmacist, limitations imposed on controlled substances, manufacturer's recommendations, and applicable state law.

When you have to file a claim. If you purchase prescriptions at a non-network pharmacy, or are unable to use your card at an NALC CareSelect Network pharmacy, complete the Short-Term claim form. Mail it with your prescription receipts to the NALC Prescription Drug Program. Receipts must include the prescription number, name of drug, prescribing doctor's name, date, charge, and name of drugstore.

When you have other prescription drug coverage, and the other carrier is primary, use that carrier's drug benefit first. After the primary carrier has processed the claim, complete the Short-Term claim form, attach the drug receipts and other carrier's payment explanation and mail to the NALC Prescription Drug Program.

NALC Prescription Drug Program
P.O. Box 686005
San Antonio, TX 78268-6005

NOTE: If you have questions about the Program, wish to locate an NALC CareSelect Network retail pharmacy, or need additional claim forms call 800/933-NALC (8:30 a.m. – 10:00 p.m., Monday thru Friday; 9:00 a.m. thru 1:00 p.m., Saturday, Eastern time).

Prescription drug benefits begin on next page.

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Covered medications and supplies	
Each new enrollee receives a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope. You may purchase the following medications and supplies from a pharmacy or by mail: • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except as shown in *Not covered* • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Drugs for sexual dysfunction (only when the dysfunction is caused by medically documented organic disease and prior authorization has been given) Here are some things to keep in mind about our prescription drug program: • A Federally-approved generic equivalent will be dispensed if it is available, unless your physician indicates "dispense as written." • If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "dispense as written" for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.	Retail: • Network Retail: 25% of cost (No deductible) • Network Retail Medicare: 15% of cost (No deductible) • Non-Network Retail: 40% of Plan allowance • Non-Network Retail Medicare: 40% of Plan allowance (No deductible) Mail Order: • 60-day supply: $8 generic/$17 name brand (No deductible) • 90-day supply: $12 generic/$25 name brand (No deductible) Mail Order Medicare: • 60-day supply: $5 generic/$13 name brand (No deductible) • 90-day supply: $7.50 generic/ $19.50 name brand (No deductible) Note: If there is no generic equivalent available, you will have to pay the name brand copay.
Not covered: • *Drugs and supplies when prescribed for cosmetic purposes* • *Vitamins, nutrients and food supplements, even when a physician prescribes or administers them* • *Over-the-counter medicines and supplies*	*All Charges*

Section 5 (g). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24-hour nurse line	You may call a registered nurse at 800/622-6252, 24 hours a day, 7 days a week, to discuss your health concerns and treatment options.
24-hour help line for mental health and substance abuse	You may call 877/468-1016, 24 hours a day, 7 days a week, to access in-person support for a wide range of concerns, including depression, eating disorders, coping with grief and loss, alcohol or drug dependency, physical abuse and managing stress.
Services for deaf and hearing impaired	TDD lines are available for the following: **CAREMARK**: 800/238-1217 (prescription benefit information) **First Health**: 800/259-8179 (PPO locator, 24-hour nurse line, medical inpatient hospital precertification, NTP) **United Behavioral Health**: 800/842-2479 (mental health and substance abuse information)
Centers of excellence for transplants/heart surgery	The Plan participates in the **First Health** National Transplant Program (NTP) that includes more than 25 centers of excellence. Call 800/622-6252 for information.
Disease management programs	These programs offer a considerable amount of personalized attention from clinicians and program educators. Nurse educators are available to discuss lifestyle changes, therapeutic outcomes, and other health related matters to assist patients in dealing with their experiences. Support is available for patients with Multiple Sclerosis, Growth Hormone Deficiency, Hemophilia, Hepatitis, Diabetes, and other diseases. You may be contacted about one of these programs.
Discounts for durable medical equipment (DME)	We have arranged with a health care provider to rent or sell durable medical equipment at discounted rates. Call us at 800/433-NALC.
Worldwide coverage	We cover the medical care you receive outside the United States subject to the terms and conditions of this brochure. See Section 7. *Overseas claims*.

Section 5 (h). Dental benefits

We have no dental benefits.

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

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

The following non-FEHB Program benefit is available only to letter carriers who are members in good standing with the National Association of Letter Carriers, their spouses, children and retired NALC members.

Hospital Plus (hospital indemnity)

Hospital Plus is a hospital indemnity policy available for purchase from the U.S. Letter Carriers Mutual Benefit Association.

Hospital Plus means money in your pocket when you are hospitalized, from the first day of your stay up to one full year. These benefits are not subject to federal income tax.

Hospital Plus allows you to choose the amount of coverage you need. You may elect to receive up to $2,250 a month, $75 a day or up to $1,500 a month, $50 a day or up to $900 a month with the $30 a day plan. Members and their spouses may select these plans. Children's coverages are limited to either $45 a day, $30 a day or $18 a day plans.

Use your benefits to pay for travel to and from the hospital, childcare, medical costs not covered by health insurance, legal fees, or any other costs.

This plan is available to all qualified members regardless of their age. Hospital Plus is renewable for lifeæyou may keep your policy for as long as you like, regardless of benefits you have received or future health conditions.

For more information, please call the United States Letter Carriers Mutual Benefit Association at 202/638-4318 Monday through Friday or 800/424-5184 Tuesdays and Thursdays, 8:00 a.m. - 3:30 p.m. EST.

Benefits on this page are not part of the FEHB contract.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations, sexual inadequacy, or sexual dysfunction (except with prior authorization);
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Charges that would not be made if a covered individual had no health insurance;
- Services furnished without charge (except as described in Section 9. *Coordinating benefits with other coverage*), while on active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat;
- Services furnished by a household member or immediate relative such as spouse, parent, child, brother or sister by blood, marriage, or adoption;
- Charges billed by a noncovered facility or provider, except medically necessary prescription drugs;
- Charges for which you or the Plan have no legal obligation to pay, such as state premium taxes or surcharges;
- Charges for interest, completion of claim forms, missed or canceled appointments, and/or administrative fees;
- Nonmedical social services or recreational therapy;
- Testing for mental aptitude or scholastic ability;
- Therapy for developmental delays, learning disabilities, stuttering, tongue thrusting, or deviate swallowing;
- Transportation (other than professional ambulance services or travel under the National Transplant Program);
- Dental services and supplies (except those oral surgical procedures listed in Section 5 (b). *Oral and maxillofacial surgery*);
- Services for and/or related to procedures not listed as covered;
- Charges in excess of the Plan allowance; or
- Treatment for cosmetic purposes and/or related expenses.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms, claims filing advice, or answers about our benefits, contact us at 703/729-4677 or 888/636-NALC (6252).

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 703/729-4677 or 888/636-NALC (6252). Send claims to:

NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149

If you are using In-Network benefits for mental health and substance abuse treatment, you will not have to submit a claim yourself. United Behavioral Health's network providers are responsible for filing. However, if you are receiving care from an Out-of-Network provider, you must file the claim yourself. Send your claim to:

United Behavioral Health
P.O. Box 23250
Oakland, CA 94623-0250

Questions? 877/468-1016

When you must file a claim — such as for overseas claims, when another group health plan is primary, or you are seeing an Out-of-Network provider — submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts must be itemized and show:

- Patient's name and relationship to enrollee;
- Enrollee identification number;
- Name and address of person or facility providing the service or supply;
- Signature of physician or supplier including degrees or credentials of individual providing the service;
- Dates that services or supplies were furnished;
- Diagnosis (ICD-9 Code);
- Type of each service or supply (CPT/HCPCS Code); and
- Charge for each service or supply.

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

In addition:

- You must send a copy of the explanation of benefits from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home health services must show that the nurse is a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.).
- Claims for rental or purchase of durable medical equipment; private nursing care; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies purchased without your card or those that are not purchased through a CareSelect Network pharmacy or the Mail Service Prescription Drug Program must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, charge, and name of drugstore.

After completing a claim form and attaching proper documentation, send all claims except prescription drug claims to: NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149-0001.

Records

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim within two years from the date the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

Claims for overseas (foreign) services must include an English translation. Charges must be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

When we need more information

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

The Plan, its medical staff and/or an independent medical review determines whether services, supplies and charges meet the coverage requirements of the Plan (subject to the disputed claims procedure described in Section 8. *The disputed claims process*). We are entitled to obtain medical or other information — including an independent medical examination — that we feel is necessary to determine whether a service or supply is covered.

Section 8. The disputed claims process

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

Step	Description

1 Ask us in writing to reconsider our initial decision. You must:

- Write to us within 6 months from the date of our decision;
- Send your request to us at: NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149;
- Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits forms.

2 We have 30 days from the date we receive your request to:

- Pay the claim (or, if applicable, arrange for the health care provider to give you the care);
- Write to you and maintain our denial — go to step 4; or
- Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3.

3 You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4 If you do not agree with our decision, you may ask OPM to review it.
You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436,Washington, D.C. 20044-0436.

Send OPM the following information:

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

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

- We haven't responded to your initial request for care or preauthorization/prior approval, then call us at 703/729-4677 or 888/636-NALC (6252) and we will expedite our review; or
- We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they too can expedite your request, or
  - You can call OPM's Health Benefits Contracts Division II at 202/606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. Like other insurers, we determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

When we are the secondary payer, we usually pay what is left after the primary plan pays, up to our regular benefit. We will not pay more than our allowance.

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. The most common ways are Original Medicare Plan and Medicare managed care plans. Medicare + Choice is the term used to describe the various managed care plans available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare plan you have.

The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you need to follow the rules in this brochure for us to cover your care.

Claims process – If Medicare is primary, you probably will never have to file a claim form.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 703/729-4677 or 888/636-NALC (6252).

We waive some costs when you have Medicare — When Medicare is the primary payer, we waive most copayments, deductibles, and coinsurance as follows:

- If you have Medicare Part A as primary payer, we waive:
  - The copayment for a hospital admission.
  - The coinsurance for a hospital admission.
- If you have Medicare Part B as primary payer, we waive:
  - The copayment for an office or outpatient visit.
  - The calendar year deductibles.
  - All coinsurance, except for inpatient hospital expenses and prescription drugs.

Note: If you have Medicare Part B as primary payer, we will not waive the copayments for mail order drugs, or the coinsurance for retail prescription drugs.

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

Primary Payer Chart		
A. When either you — or your covered spouse — are age 65 or older and…	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under Title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of Title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you — or a covered family member — have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee		✓

Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 800/MEDICARE (800/633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area. We waive coinsurance, deductibles, and most copayments when you use a participating provider with your Medicare managed care plan. If you receive services from providers that do not participate in your Medicare managed care plan, we do not waive any coinsurance, deductibles, or copayments.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

- Private Contract

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

- Enrollment in Medicare Part B

Note: We cannot require you to enroll in Medicare. If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

Subrogation/Reimbursement guidelines. The Plan has a right to recover payments made to you by a third party or third party's insurer when the third party caused your illness or injury. "Third party" means another person or organization. Our right to reimbursement is limited to the amount we have paid or will pay because of the illness or injury.

You must notify us promptly if you are seeking a recovery from a third party because of the act or omission of another person. Further, you must notify us of any recovery you receive, whether in or out of court, and you must reimburse us to the extent the Plan paid benefits.

We will pay benefits for your illness or injury provided you do not interfere with our attempts to recover the amounts we have paid in benefits, and that you assist us in obtaining a recovery. If we have paid benefits and you recover money from the third party, you must reimburse us for the benefits we paid. If you do not seek damages from the third party, you must agree to let us seek damages. We may require you to assign the proceeds of your claim or the right to take action against the third party, and we may withhold payment until the assignment is provided.

All payments from the third party must be used to reimburse the Plan for benefits paid. Our share of the recovery is not reduced because you do not receive the full amount of damages claimed, unless we agree in writing to a reduction. Any reduction of our claim for payment of attorney's fees or costs related to the claim is subject to prior approval by the Plan.

Section 10. Definitions of terms we use in this brochure

Admission

The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as a single day.

Assignment

Your authorization for us to issue payment of benefits directly to the provider. We reserve the right to pay you directly for all covered services.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Congenital anomaly

A condition that existed at or from birth and is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include protruding ear deformities, cleft lips, cleft palates, birthmarks, webbed fingers or toes, and other conditions that the Carrier may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structure supporting the teeth.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.*Your costs for covered services.*

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See Section 4.*Your costs for covered services.*

Cosmetic surgery

Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

Covered services

Services we provide benefits for, as described in this brochure.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that can safely and reasonably be rendered by a person not medically skilled, or that are designed mainly to help the patient with daily living activities, such as:

- Personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
- Homemaking, such as preparing meals or special diets;
- Moving the patient;
- Acting as companion or sitter;
- Supervising self-administered medication; or
- Treatment or services that any person may be able to perform with minimal instruction, such as recording temperature, pulse, and respirations; or administration and monitoring of feeding systems.

The Plan determines whether services are custodial care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.*Your costs for covered services.*

Effective date

The effective date of benefits described in this brochure is:

- January 1 for continuing enrollments and for all annuitant enrollments;
- The first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during the Open Season; or
- Determined by the employing office or retirement system for enrollments and changes that are not Open Season actions.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot lawfully be marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety,

its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Our Medical Director reviews current medical resources to determine whether a service or supply is experimental or investigational. We will seek an independent expert opinion if necessary. Call us to obtain information about our determination process.

Group health coverage

Coverage through employment (including benefits through COBRA) or membership in an organization that provides payment for hospital, medical, or other health care services or supplies, or that pays more than $200 per day for each day of hospitalization.

Medical necessity

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

- Are appropriate to diagnose or treat your condition, illness, or injury;
- Are consistent with standards of good medical practice in the United States;
- Are not primarily for the personal comfort or convenience of you, your family, or your provider;
- Are not related to your scholastic education or vocational training; and
- In the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug, or equipment does not, in itself, make it medically necessary.

Mental health and substance abuse

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

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways.

Our Plan allowance is the negotiated rate when you use:

- PPO providers;
- Network mental health providers;
- Network retail pharmacies; or
- Our mail order pharmacy.

These providers accept the Plan allowance as their charge.

When you do not use one of the above providers, our Plan allowance is based on the prevailing charge made by other providers within the geographic area in which the service or supply is provided for illness or injury of comparable severity and nature in the absence of insurance. This allowance is determined from data prepared by Ingenix, Inc., including both the Prevailing Healthcare Charges System (PHCS) and Medical Data Research (MDR). Inpatient and outpatient surgical procedure data is from PHCS. Data for physician and other professional services and laboratory and X-ray procedures is prepared by MDR. We pay claims based on the 90th percentile for both PHCS and MDR. This data is updated twice per year. For other categories of benefits and for certain specific services within each of the above categories, exceptions to the general method of determining the Plan allowance may exist.

For more information, see Section 4. *Differences between our allowance and the bill*.

Pre-admission testing

Routine tests ordered by a doctor and usually required prior to surgery or hospital inpatient admission that are not diagnostic in nature.

Us/We

Us and we refer to the NALC Health Benefit Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

Coverage information

- **No pre-existing condition limitation**

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

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

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions and give you a *Guide to Federal Employees Health Benefit Plans,* brochures for other plans. and other materials you need to make an informed decision about.

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

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

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

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren for whom coverage is authorized. Under certain circumstances, you may continue coverage for a disabled/incapable of self-support child age 22 or older.

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

- **Your medical and claims records are confidential**

We keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;

- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education when your identity is not disclosed;
- OPM, when reviewing a disputed claim or defending litigation about a claim; or
- Treating physicians or dispensing pharmacies, as part of the Plan's administration of the prescription drug program.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

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

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

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

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

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after he or she becomes eligible for TCC, or receives this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce

continues on next page

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notifies your employing or retirement office within the 60-day deadline.

- **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 703/729-4677 or 888/636-NALC (6252) and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

- **Penalties for Fraud**

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they try to obtain services for a person who is not an eligible family member, or are no longer enrolled in the Plan and try to obtain benefits. Your agency may also take administrative action against you.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA area
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2000 Open Season, November 13, 2000, through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions, and forms. The toll-free phone number for the IPC is 877/DOD-FEHB (877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 open seasons. Your coverage will begin January 1 of the year following the Open Season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

TCC eligibility

See Section 11. FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under Title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for the NALC Health Benefit Plan – 2001

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $250 PPO or $300 Non-PPO calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: $20 copayment per office visit; $5 copayment per allergy injection; $5 - $25 copayment per routine screening service; other nonsurgical services, 15%* of our allowance Non-PPO: 30%* of our allowance	14
Services provided by a hospital: • Inpatient • Outpatient	PPO: Nothing Non-PPO: $100 copayment per admission, 20% of charges PPO: 15%* of our allowance Non-PPO: 30%* of our allowance	26 27
Emergency benefits: • Accidental injury • Medical emergency	Within 72 hours: Nothing for nonsurgical outpatient care After 72 hours: PPO: 15%* of our allowance Non-PPO: 30%* of our allowance Regular benefits	29 30
Mental health and substance abuse treatment	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	31 33
Prescription drugs	Network Retail: 25% of cost Network Retail Medicare: 15% of cost Non-Network Retail: $25 deductible, 40% of our allowance Non-Network Retail Medicare: 40% of our allowance Mail Order: 60-day supply, $8 generic/$17 name brand Mail Order: 90-day supply, $12 generic/$25 name brand Mail Order Medicare: 60-day supply, $5 generic/$13 name brand Mail Order Medicare: 90-day supply, $7.50 generic/$19.50 name brand	34
Dental Care	No benefit	37
Special features: • Flexible benefits option • 24-hour nurse line • Services for deaf and hearing impaired • Centers of excellence for transplants/heart surgery • Disease management programs • Discounts for durable medical equipment (DME) • Worldwide coverage • 24-hour help line for mental health and substance abuse		36
Protection against catastrophic costs (your out-of-pocket maximum)	Services with coinsurance (excluding mental health and substance abuse care), nothing after your coinsurance expenses total: • $3000 for PPO providers/facilities • $3500 for Non-PPO providers/facilities. When you use a combination of PPO and Non-PPO providers your out-of-pocket expense will not exceed $3500. Mental health and substance abuse benefits, nothing after your coinsurance expenses total: • $3000 for In-Network mental health and substance abuse providers/facilities • $8000 for Out-of-Network mental health and substance abuse inpatient hospital treatment (after 50 days you pay all charges) Some costs do not count toward this protection.	10

2001 Rate Information for
NALC Health Benefit Plan

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

Postal rates apply to most career U.S. Postal Service employees. Different rates apply if you are a Postal Service nurse or tool and die employee. Refer to the FEHB Guide (for Postal Service nurses and tool and die employees), RI 70-2B. If you are a Postal Service Inspector or Office of Inspector General (0IG) employee, refer to FEHB Guide RI 70-21N.

Postal rates do not apply to non-career postal employees, postal retirees or associate members of any postal employee organization, Such persons not subject to postal rates must refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	321	$86.59	$49.01	$187.61	$106.19	$102.22	$33.38
High Option Self and Family	322	$195.82	$93.92	$424.28	$203.49	$231.17	$58.57