NALC Health Benefit Plan

1999

A Managed Fee-for-Service Plan with a Preferred Provider Organization

Sponsored and administered by: the National Association of Letter Carriers, AFL-CIO

Who may enroll in this Plan: All Federal and Postal Service employees and annuitants who are eligible to enroll in the FEHB Program may become members of this Plan. To enroll, you must be, or must become, a member of the National Association of Letter Carriers.

To become a member or associate member: All active Postal Service employees must be dues paying members of an NALC local. Enter the number of your local immediately after the name of this Plan in Item 1 of Part B of your registration form.

If you are a non-postal employee/annuitant you will automatically become an associate member of NALC upon enrollment in the NALC Health Benefit Plan.

Annuitants (retirees) may enroll in this Plan.

Membership dues: $36 per year for an associate membership. New associate members will be billed for annual dues when the Plan receives notice of enrollment. Continuing associate members will be billed by NALC for the annual membership. Active and retired Postal Service employees' membership dues vary by NALC local.

Enrollment code for this Plan:
321 Self Only
322 Self and Family

Visit the OPM website at http://www.opm.gov/insure.
and
Visit the NALC Health Benefit Plan website at http://www.nalc.org/hbp.

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 71-9

NALC Health Benefit Plan

The National Association of Letter Carriers has entered into Contract No. CS 1067 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is the official statement of benefits on which you can rely. It describes the benefits, exclusions, limitations, and maximums of the NALC Health Benefit Plan for 1999 until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for **FRAUD** which may result in **CRIMINAL PENALTIES**.

Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800/433-NALC and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C., 20415

The inappropriate use of membership identification cards, e.g., to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

When you need help with Plan benefits, or getting your ID card, call your Plan at 703/729-4677. The Fraud Hotline cannot help you with these.

Using This Brochure

The **Table of Contents** and **Index** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers**. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits,** on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are paid after you satisfy the calendar year deductible and Additional Benefits are not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid one way if it is billed by an inpatient facility and paid another way when it is billed by a doctor, physical therapist or outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification;** generally, hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare**. And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

Table of Contents

How This Plan Works — Page

Help Contain Costs 4
Ways you and the Carrier can work together to keep costs down

Facilities and Other Providers 4
Medical personnel and facilities covered by this Plan and how your choice of provider will affect what you pay for benefits

Cost Sharing 6
What you need to know about deductibles, coinsurance and copayments, your share of covered health care expenses, and the maximum amounts this Plan will pay for certain types of care

General Limitations 7
How the Plan works if you have other health care coverage or receive health care services through another Government program; limit on your costs if you are 65 or older and don't have Medicare

General Exclusions 9
What is not covered by this Plan

Benefits

Inpatient Hospital Benefits 10
Your benefits for inpatient hospital care (see below for mental conditions/substance abuse care)

Surgical Benefits 11
Your benefits for doctors' services for inpatient and outpatient surgery and related procedures/ services and supplies

Maternity Benefits 14
Your benefits for prenatal care, childbirth, contraceptives and infertility treatment

Mental Conditions/Substance Abuse Benefits 15
Your benefits for outpatient, inpatient and other facility care for mental conditions, alcoholism, and drug abuse

Other Medical Benefits (deductible applies) 16
Your benefits for doctors' home and office visits, routine screening services, ambulance service, durable medical equipment (e.g., crutches and hospital beds), allergy tests and injections, chemo-therapy, radiation therapy and physical, occupational and speech therapy

Additional Benefits (no deductible) 18
Your benefits for outpatient care for accidental injury, childhood immunizations, pap smears, skilled nursing care, skilled nursing facility, and well child care

Prescription Drug Benefits 18
Your benefits for prescription drugs and supplies you get from pharmacies or by mail order

How to Claim Benefits 20
Getting your claims paid when your provider does not file them for you; how to ask OPM to review a claims dispute between you and the Carrier

Protection Against Catastrophic Costs 22
The maximum amount of covered expenses you can expect to pay for health care

Other Information

Information you have a right to know 23

Precertification 23
Hospital stays must be precertified to avoid a $500 benefit reduction

This Plan and Medicare 24
Information you need if you are covered by Medicare

Enrollment Information 26
Your enrollment in the Federal Employees Health Benefits Program and how to maintain FEHB coverage when enrollment ends

Definitions 29
Explanations of some of the terms used in this brochure

Index 31
List of covered benefits and services, with page numbers

Non-FEHB Benefits 33
Other services available to letter carriers

How This Plan Changes

How the NALC Health Benefit Plan Changes January 1999 34

Summary of Benefits

High Option 35

Help Contain Costs

You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and the flexible benefits option. Some include managed care options, such as PPO's, to help contain costs.

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on pages 23-24 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Carrier has the authority to determine the most effective way to provide services. The Carrier may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. The Carrier may decide to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely the Carrier's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

PPO

This Plan offers most of its members the opportunity to reduce out-of-pocket expenses by choosing providers who participate in the Plan's preferred provider organization (PPO). Consider the PPO cost savings when you review Plan benefits and check with the Carrier to see whether PPO providers are available in your area.

Facilities and Other Providers

Covered facilities

Birthing center

A free-standing 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/certified by the jurisdiction in which it operates; 3) is supervised by a staff of doctors (M.D. or D.O.) with at least one such doctor 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

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

In no event shall the term "hospital" 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 licensed or certified by the State or eligible for payment under Medicare that provides continuous non-custodial inpatient skilled nursing care by an organized medical staff for post-hospital patients.

Treatment facility

A freestanding institution separately licensed by the jurisdiction for rehabilitative treatment of alcoholism or drug abuse on its premises 24 hours a day and that maintains a course of treatment based on the patient's individual needs.

Covered providers

For purposes of this Plan, covered providers include:

1) 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.), practicing within the scope of their license.

2) A nurse anesthetist (CRNA).
3) 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.
4) Other providers listed with the benefits sections.
5) Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist, and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1999, the States designated as medically underserved are: Alabama, Idaho, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota and Wyoming.

PPO arrangements

Benefits under this Plan are available from facilities, such as hospitals, and from providers, such as doctors and other health care personnel, who provide covered services. This Plan covers two types of facilities and providers: (1) those who participate in a preferred provider organization (PPO) and (2) those who do not. Who these health care providers are, and how benefits are paid for their services, are explained below. In general, it works like this.

PPO facilities and providers have agreed to provide services to Plan members at a lower cost than you'd usually pay a non-PPO provider. Although PPOs are not available in all locations or for all services, when you use these providers you help contain health care costs and reduce what you pay out of pocket. The selection of PPO providers is solely the Carrier's responsibility; continued participation of any specific provider cannot be guaranteed. While PPO providers agree with the Carrier to provide covered services, final decisions about health care are the sole responsibility of the doctor and patient; and are independent of the terms of the insurance contract.

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

When you use a PPO hospital, keep in mind that 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.

Non-PPO facilities and providers do not have special agreements with the Plan. The Plan makes its regular payments toward the bills, and you're responsible for any balance.

This Plan's PPO

The Plan offers you a broad, national PPO network. If you choose a PPO provider, then you will be eligible for the enhanced PPO benefit levels described below. Please understand that PPO providers may not be available in all geographic regions, particularly in Maine and Maryland due to state laws affecting provider contracting (Maryland has no hospital network and Maine has no hospital network and no physician/outpatient care network). Information on PPO providers in specific regions is available through the Plan's toll free provider locator service (1-800-622-6252), website (www.firsthealth.com/MainMenu.hcc?Polnum=NAL), or PPO directories. In areas where a PPO provider is unavailable, members can choose a non-PPO provider and receive standard non-PPO benefits under the Plan.

When a PPO hospital is used, the $100 per admission deductible and the 20% coinsurance are waived for medical, surgical and maternity confinements (other hospital charges are covered at 100%) and the per admission deductible for mental conditions confinements is $400. For PPO doctors' outpatient office visits, the Plan pays 100% of the negotiated rate after a $15 copayment per visit. All other services by PPO doctors and health care professionals are paid at 80% of the negotiated rate under Other Medical Benefits after satisfaction of the $275 calendar year deductible.

When admitted to a PPO network hospital, show your NALC identification card to the admissions department and advise them that NALC participates in the PPO program. Also make an assignment of benefits to the hospital. The hospital will then file the claim on your behalf. Benefits will be paid to the hospital. **Enrollees residing in a PPO region will receive a listing of the PPO hospitals and health care institutions in their service area.** Contact the Plan at 1-800/548-8454 for information or to obtain a list of PPO hospitals in your area.

Follow the same procedures when visiting a PPO doctor. The doctor and other health care professional networks are generally in the same geographic areas as the hospitals. For information on general practitioners and specialists in those areas, call 1-800/622-6252. The Plan is solely responsible for the selection of PPO providers and any questions regarding PPO providers should be directed to the Plan. When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

Cost Sharing

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of covered expenses an individual must incur each calendar year before the Plan pays certain benefits. The separate calendar year deductibles apply as follows: Other Medical Benefits – $275; Inpatient services under Substance Abuse Benefits– $250; and inpatient and outpatient professional services under Mental Conditions/Substance Abuse Benefits –$250; and Retail pharmacy – $25.

Each of these deductibles applies to each individual once during a calendar year regardless of how many illnesses, or injuries the person may have. Only those expenses covered under each provision may be applied toward that deductible. Charges in excess of the reasonable and customary fee, incurred while not enrolled in this Plan, or considered under other benefit provisions (unless specifically listed) do not count toward the deductibles.

Hospital admission

There is a $100 deductible per inpatient hospital medical, surgical, or maternity admission and a $500 deductible per inpatient mental conditions admission. However, if a PPO hospital is used, the medical per admission deductible is waived, and the deductible for inpatient mental conditions admissions is $400 (see page 15).

Carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible in the prior year will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Family limit

Under family enrollment, the Other Medical Benefits deductible and the retail pharmacy deductible are considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the deductible reach $550 (Other Medical Benefits) and $50 (retail pharmacy) in a calendar year.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The Plan will base this percentage on either the billed charge **or** the usual, reasonable and customary charge, whichever is less. For instance, under Other Medical Benefits, when the Plan pays 70% of reasonable and customary charges for a covered service, you are responsible for 30% of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges $100 for a service but the Plan's reasonable and customary allowance is $95, the Plan will pay 70% of the allowance ($66.50). You must pay the 30% coinsurance ($28.50), plus the difference between the actual charge and the reasonable and customary allowance ($5), for a total member responsibility of $33.50. Remember, under Other Medical Benefits, services and supplies by a PPO provider will be payable at 80% of negotiated rates, and if surgery is performed by a PPO doctor, benefits are payable at 85% of negotiated rates, not 70% as for non-PPO doctors.

When hospital charges are limited by law

When inpatient claims are paid according to a Diagnostic Related Group (DRG) limit (for instance, for admissions of certain retirees who do not have Medicare - see page 8), the Plan will pay 30% of the total covered amount as room and board charges and 70% as other charges and will apply your coinsurance accordingly.

Copayments

A copayment is the stated amount the Plan requires you to pay for certain covered services, such as $12 per prescription for generic mail order drugs or $15 per office visit at a PPO provider.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges $100 for a service but routinely waives the 30% coinsurance, the actual charge is $70. The Plan will pay $49 (70% of the actual charge of $70).

Lifetime maximums

Substance abuse benefits are limited to a lifetime maximum per person of 30 days room and board and ancillary charges in a treatment facility; Hospice care benefits are limited to a lifetime maximum of $3,000; and Smoking cessation benefits are limited to a lifetime maximum of $100.

General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan. This brochure is the official statement of benefits on which you can rely.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B**,** or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 24-26 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is 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. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of reasonable and customary charges.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statute governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation means the Plan's right to recover payments made to you or your dependent by a third party or third party's insurer because of illness or injury caused by a third party. Third party means another person or organization. If you or your covered dependent suffers an injury or illness through the act or omission of another, the Plan requires that it be reimbursed for benefits paid by the Plan in an amount not to exceed the amount of the recovery, or that it be subrogated to your (or your dependent's) rights to the extent of the benefits paid, including the right to bring suit. All recoveries from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse the Plan for benefits paid. The Plan's share of the recovery will not be reduced because you or your dependent do not receive the full amount of damages claimed, unless the Plan agrees in writing to a reduction.

If you or your dependent are injured because of a third party's action or omission: 1) The Plan will pay benefits for that injury subject to the conditions that you and your dependent: a) do not take any

action that would prejudice the Plan's ability to recover benefits; and b) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery. 2) The Plan's right of reimbursement extends only to the amount of Plan benefits paid or to be paid because of the injury. 3) The Plan may insist upon an assignment of the proceeds of the claim or right of action against the third party and may withhold payment of benefits otherwise due until the assignment is provided.

You are required to notify the Plan promptly of any third party claim that you may have for damages for which the Plan has paid or may pay benefits. In addition, you are required to notify the Plan of any recovery, whether in or out of court, that you or your dependent obtain and to reimburse the Plan to the extent of benefits paid by the Plan. Any reduction of the Plan's claim for payment of attorney's fees or costs associated with the claim is subject to prior approval by the Plan. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are **not** covered by either **Medicare Part A** (hospital insurance) or **Part B** (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by **Medicare Part A,** are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the **equivalent Medicare amount.** After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan for assistance.

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have **Medicare Part B** are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the **Medicare-approved amount** (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. If your doctor is a member of the Plan's preferred provider organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO doctor who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, unless the doctor's agreement with the Carrier specifies otherwise, you must pay the difference between the Medicare-approved amount and the **limiting charge** (115% of the Medicare approved amount).

If your physician is not a Plan PPO doctor but participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's surgery benefit, the Plan will pay 70% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 30% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases, you will be responsible for any deductible, the coinsurance or copayment amount, **and** any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan for assistance.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 7); while in 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
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother or sister by blood, marriage or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction or sexual inadequacy (except as provided on page 19)
- Not specifically listed as covered or received in connection with a procedure not listed as covered
- Investigational or experimental
- Not provided in accordance with accepted professional medical standards in the United States
- Furnished by practitioners other than those defined as covered providers on pages 4-5
- Obtained while not covered by this Plan

Benefits will not be paid for:

- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived.
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 8), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge)(see pages 25-26), or State premium taxes however applied.
- Procedures, services, drugs and 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.
- Any portion of a fee that the Plan determines to be in excess of the reasonable and customary charge
- Any treatment for cosmetic purposes
- Custodial care as defined on page 29
- Injections of growth hormones and related supplies, except when preauthorization has been obtained through the Plan (see page 17)
- Interest, charges for completion of claim forms or missed or cancelled appointments, or similar administrative charges made by providers
- Nonmedical social services; recreational therapy; educational and training services; and training in activities of daily living
- Nonsurgical treatment for weight reduction or obesity
- Speech therapy, except as provided on page 17
- Testing for mental aptitude or scholastic ability
- Therapy for developmental delays, learning disabilities, stuttering, tongue thrusting or deviate swallowing
- Transportation or travel (other than covered ambulance services and travel under the managed transplant system)
- Standby physicians and surgeons, except during angioplasty or other high risk procedures when the Plan determines standbys are medically necessary
- Dental services and supplies except those oral surgical procedures listed on page 12

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

Precertification

The medical necessity of your hospital admission **must** be precertified for you to receive full Plan benefits. Emergency admissions not precertified 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 pages 23-24 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. For information on when Medicare is primary, see page 25.

Room and board

Plan pays for ward, semiprivate or intensive care accommodations including general nursing care, meals and special diets furnished by a hospital for an inpatient. Charges for a private room will be covered only when the patient's isolation is required by law or the Plan determines that isolation is required to prevent contagion. If for any other reason a private room is used, the Plan will pay the hospital's average charge for semiprivate accommodations. If the hospital has private accommodations only, the average semiprivate rate is determined on the basis of the charges of the most comparable hospital in the area.

PPO benefit

Plan pays room and board at **100%** with no deductible when admission is to a PPO hospital. See page 5.

Non-PPO benefit

After a $100 deductible per admission, Plan pays room and board at **80%.**

Flat rate hospital charges for non-PPO hospitals are prorated: 30% room and board and 70% other charges. Other prorations may apply to PPO hospitals for which rates are negotiated. (See page 6, *When hospital charges are limited by law.)*

Other charges

Plan pays for other covered inpatient services and supplies as shown below:

- Professional ambulance service to the nearest hospital equipped to handle the patient's condition
- Anesthetics and oxygen including nurse anesthetist services
- X-ray and laboratory tests
- Blood or blood plasma, if not donated or replaced
- Internal prostheses, including the first internal breast prosthesis following a mastectomy
- Drugs and medicines
- Additional ancillary services such as operating, recovery and treatment rooms, equipment and dressings, splints and casts

PPO benefit

Plan pays Other charges at **100%** when admission is to a PPO hospital. See page 5.

Non-PPO benefit

Plan pays Other charges at **80%**.

Limited benefits

Pre-admission testing

Plan pays for pre-admission testing within 7 days of admission or outpatient surgery. Covered screening tests include chest X-rays, electrocardiograms, urinalyses and blood work but do not include diagnostic tests such as magnetic resonance imaging, throat cultures or similar studies.

PPO benefit

Plan pays for pre-admission testing at **100%** when provided by a PPO hospital. See page 5.

Non-PPO benefit

Plan pays for pre-admission testing at **80%.**

Hospitalization for dental work and foot treatment

Plan pays benefits for hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. Hospital benefits for inpatient foot treatment are payable even if no other benefits are payable.

Inpatient Hospital Benefits *continued*

Related benefits

Professional charges

Doctors' inpatient medical visits are covered under Other Medical Benefits. For inpatient services by anesthesiologists, radiologists and pathologists:

PPO benefit

Plan pays **80%** of negotiated rate. See page 5.

Non-PPO benefit

Plan pays **70%** of the reasonable and customary charge.

Take-home items

Medical supplies, appliances, medical equipment and any covered items billed by a hospital for use at home are covered only under Other Medical Benefits.

What is not covered

- Room and board and doctor care when, in the Carrier's judgment, an admission or portion thereof is not medically necessary, i.e., the medical services did not require the acute care setting, but could have been provided in a doctor's office, hospital outpatient department, skilled nursing facility or other setting without adversely affecting the patient's condition or the quality of medical care rendered. In this event, the Carrier will pay benefits for services and supplies other than room and board and in-hospital physician care at the level at which they would have been covered if provided in an alternative setting.
- Room and board in institutions which do not meet the definition of *Covered facilities* on page 4, such as nursing homes, extended care facilities, schools, residential treatment centers, halfway houses or which have as their primary purpose the furnishing of food, shelter, training or non-medical personal services
- Personal comfort items, such as telephone, television, barber services, guest meals and beds
- Surcharges made by hospitals
- Private duty nursing care while confined in a hospital
- Custodial care as defined on page 29

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.

Surgical Benefits

What is covered

The Plan pays for the following services:

Hospital inpatient/outpatient

Surgeons' charges, including procedures for sterilization and gastric bypass for morbid obesity.

PPO benefit

If the surgery is performed by a Plan PPO network doctor, benefits for the inpatient or outpatient surgical procedure will be payable at **85%** of the surgeon's negotiated rate after satisfaction of the $275 calendar year deductible; see page 6.

Non-PPO benefit

If the surgery is not performed by a Plan PPO network doctor, benefits for the inpatient or outpatient surgical procedure will be payable at **70%** of the reasonable and customary charge after satisfaction of the $275 calendar year deductible.

Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan will consider as an eligible expense the reasonable and customary charge for the first or major procedure in full plus one-half the value of the second or lesser procedure(s).

Incidental procedures

When an incidental procedure *(e.g.,* appendectomy, lysis of adhesion, puncture of ovarian cyst) is performed through the same incision, the benefit shall be that of the major procedure only. Separate benefits will not be provided for procedures deemed by the Plan to be incidental to the total surgery.

Assistant surgeon (inpatient/ outpatient)

For assistant surgeons' fees, the Plan will consider up to 25% of the reasonable and customary surgical charge as a covered expense.

Second opinion (voluntary)

Charges for a second surgical opinion (or a third opinion if the second opinion does not confirm the initial recommendation) are considered under Other Medical Benefits.

Surgical Benefits *continued*

Related benefits

Professional charges

Inpatient: see Professional charges on page 11.
Outpatient services by anesthesiologists, radiologists and pathologists:

PPO benefit

Plan pays **80%** of negotiated rate after satisfaction of the $275 calendar year deductible.

Non-PPO benefit

Plan pays **70%** of the reasonable and customary charge after satisfaction of the $275 calendar year deductible.

Organ/tissue transplants and donor expenses

What is covered

The following human organ/tissue transplant procedures are covered, subject to the conditions and limitations below:

- Bone, cornea, heart, heart/lung, kidney, liver, pancreas, and kidney/pancreas
- Single or double lung transplants, limited to patients for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension, or emphysema; double lung transplants, limited to patients with cystic fibrosis.

Bone marrow transplants and stem cell support as follows:

- Allogeneic 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-lymphocytic 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.

Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan. Recipient means an insured person who undergoes an operation to receive an organ transplant. Donor means a person who undergoes an operation for the purpose of donating an organ for transplant surgery.

National transplant program

The Plan participates in a National Transplant Program administered by First Health. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact First Health at 1-800/622-6252 and ask to speak to a Transplant Case Manager. You will be provided with information about this program and about transplant preferred providers.

The reasonable and customary 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 costs.

Limited benefits

If prior approval is not obtained or a designated facility is not used, pretransplant evaluation, organ procurement, inpatient hospital, surgical and medical expenses for covered transplants, whether incurred by the recipient or donor, are limited to a maximum of $100,000 for each listed transplant (kidney limit, $50,000).

What is not covered

- Donor screening tests for organ transplants, except those performed for the actual donor
- Implants of artificial organs
- Transplants not listed as covered

Oral and maxillofacial surgery

The following oral surgical procedures are covered:

- Reduction 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.

Surgical Benefits *continued*

Mastectomy surgery

Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

What is not covered

- Oral implants and transplants
- Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)
- Voluntary reversal of surgical sterilization
- Cutting, trimming or removal of corns, calluses or the free edge of toenails, and similar routine treatment of conditions of the foot, except when necessary because the individual is under active treatment for a metabolic or peripheral vascular disease
- Refractive keratoplasty or radial keratotomy
- Cosmetic surgery (see definition on page 29), except for repair of accidental injury if repair is initiated within six months after an accident, to correct a congenital anomaly of a child born under the Program, and for breast reconstruction following a mastectomy
- Standby physicians and surgeons, except during angioplasty or other high risk procedures when the Plan determines standbys are medically necessary.

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.

Maternity Benefits

What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary.

Inpatient hospital

Precertification

Precertification is not required for maternity admissions for routine deliveries. However, if your medical condition requires that you stay more than 48 hours after a regular delivery or 96 hours after a cesarean section, you, your physician or the hospital must contact the Plan for certification of the additional days. If the certification for additional days is not obtained and a retrospective medical review determines the additional days were not medically necessary, the Plan will not pay for charges incurred on those noncertified days. If certification is not obtained but the benefits are otherwise payable, benefits for the admission will be reduced by $500. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 23-24 for details.

Room and board

Plan pays for ward, semiprivate or intensive care accommodations including general nursing care, meals and special diets furnished by a hospital for an inpatient.

PPO benefit

Plan pays room and board at **100%** with no deductible when admission is to a PPO hospital. See page 5.

Non-PPO benefit

After a $100 deductible per admission, Plan pays room and board at **80%.**

Flat rate hospital charges for non-PPO hospitals are prorated: 30% room and board and 70% other charges. Other prorations may apply to PPO hospitals for which rates are negotiated. (See page 6, *When hospital charges are limited by law.)*

Other charges

Plan pays for other covered hospital services and supplies. See Inpatient Hospital Benefits.

PPO benefit

Plan pays Other charges at **100%** when admission is to a PPO hospital. See page 6.

Non-PPO benefit

Plan pays Other charges at **80%.**

Ordinary bassinet or nursery charges on days when the mother would normally be confined after delivery are considered hospital expenses of the mother. Other expenses of the child will be considered the child's own and will be payable only if the child is covered under a Self and Family enrollment and if the confinement is for the treatment of illness or injury of the child.

Outpatient care

The Plan pays the same benefits as listed above for admission to a birthing center.

Obstetrical care

Plan pays delivery fees (including prenatal and postpartum care), and services of doctors and nurse midwives.

PPO benefit

If the delivery is performed by a Plan PPO network provider, the benefit for delivery will be payable at **85%** of the negotiated rate after satisfaction of the $275 calendar year deductible; see page 6.

Non-PPO benefit

If the delivery is performed by a non-PPO provider, the benefit for delivery will be payable at **70%** of the reasonable and customary charge after satisfaction of the $275 calendar year deductible.

Related benefits

Diagnosis and treatment of infertility

Diagnostic testing and treatment of infertility (except as excluded below) are covered under Other Medical Benefits.

Testing

Group B streptococcus infection screening of pregnant women, sonograms, fetal monitoring, and other related tests medically indicated for the unborn child are covered under Other Medical Benefits. Amniocentesis is covered under Surgical Benefits.

Voluntary sterilization

See Surgical Benefits.

For whom

Benefits are payable under Self Only enrollments and for family members under Self and Family enrollments.

What is not covered

- Routine sonograms to determine fetal age, size or sex
- Assisted Reproductive Technology (ART) procedures such as artificial insemination, in vitro fertilization, embryo transfer and GIFT, as well as services and supplies related to ART procedures are not covered.
- Contraceptive implants and devices
- Genetic counseling

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.

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Mental conditions

Inpatient care

Plan pays for ward or semiprivate accommodations and other hospital charges at **50%** up to 50 days per calendar year, after the stated deductible.

PPO benefit

After satisfaction of a $400 deductible per admission, Plan pays **50%** of charges up to 50 days per calendar year when admission is to a PPO hospital. See page 5.

Non-PPO benefit

After satisfaction of a $500 deductible per admission, Plan pays **50%** of charges up to 50 days per calendar year. (See page 6, *When hospital charges are limited by law.)*

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan 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 pages 23-24 for details.

Inpatient visits and outpatient care

See Professional services below.

Catastrophic protection

The Plan pays 100% of covered charges for the remainder of the calendar year, after your coinsurance on out-of-pocket expenses for inpatient mental conditions care total $8,000, not to exceed the calendar year maximum of 50 days.

Substance abuse

Inpatient care

After satisfaction of a separate $250 inpatient Substance Abuse calendar year deductible, room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse are paid at **50%** and are limited to a 30-day lifetime maximum per person. (See page 6, *When hospital charges are limited by law.)*

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan 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 pages 23-24 for details.

Inpatient visits and outpatient care

See Professional services below.

Lifetime maximum

There is a 30-day lifetime maximum per person for inpatient rehabilitative substance abuse care.

Mental conditions/ substance abuse

Professional services

PPO benefit

After satisfaction of a $250 Mental conditions/Substance abuse calendar year deductible, the Plan pays **60%** of charges for inpatient and outpatient services by covered providers for treatment of mental conditions/substance abuse up to a maximum of 30 visits.

Non-PPO benefit

After satisfaction of a $250 Mental conditions/Substance abuse calendar year deductible, the Plan pays **50%** of charges for inpatient and outpatient services by covered providers for treatment of mental conditions/substance abuse up to a maximum of 30 visits.

What is 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
- Room and board and doctor care when, in the Carrier's judgement, an admission or portion thereof, is not medically necessary, i.e., the medical services did not require the acute care setting, but could have been provided in a doctor's office, hospital outpatient department, or some other setting without adversely affecting the patient's condition or the quality of care rendered.

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.

Other Medical Benefits

What is covered

Outpatient office visits

Benefits for visits to a doctor's office are covered as follows:

PPO benefit

After you pay a $15 copayment for each covered outpatient office visit with a PPO provider (see page 5), the Plan pays **100%** of the negotiated rate. The $275 calendar year deductible does not apply to this benefit. Home and hospital visits, consultations and second opinions are covered under Other services below.

Non-PPO benefit

After the $275 calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges for covered outpatient office visits provided by a non-PPO provider.

Other services

PPO benefit

After the $275 calendar year deductible has been met, the Plan pays **80%** of the negotiated rate for the following services and supplies provided by a Plan PPO network provider. See page 5.

Non-PPO benefit

After the $275 calendar year deductible has been met, the Plan pays **70%** of reasonable and customary charges for the following services and supplies provided by a non-PPO provider.

- Doctors' nonsurgical services for home and hospital visits, medical consultations and second surgical opinions, except surgical follow-up care covered under Surgical Benefits
- Initial examination of a newborn child covered under a Self and Family enrollment
- Acupuncture by a doctor of medicine or osteopathy

Services and supplies outside a hospital (or as a hospital outpatient) prescribed by the attending doctor, as follows:

- Insulin and diabetic supplies (also see *Prescription Drug Benefits,* page 18)
- Allergy tests and treatments, including injectable antigens
- Needles and syringes for covered injectables and ostomy and catheter supplies
- Home IV and antibiotic therapy
- Local professional ambulance service when medically appropriate
- Anesthetics and their administration
- Oxygen
- Hemodialysis and peritoneal dialysis
- Artificial limbs and eyes; stump hose
- Chemo- and radiation therapy; high dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 12
- Blood and blood plasma, if not donated or replaced
- Specially made durable leg, arm, neck and back braces
- Diagnostic X-rays, laboratory tests and pathology services
- Outpatient hospital charges related to dental procedures only when necessitated by a non-dental physical impairment
- First externally worn breast prosthesis immediately following a mastectomy
- One pair of eyeglasses or contact lenses if required to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)
- First hearing aid and testing only when necessitated by accidental injury

Durable medical equipment (DME)

What is covered

- Rental or purchase, at the Plan's option, including repair and adjustment, of oxygen apparatus, dialysis appliances and similar durable medical equipment. Also included are hospital beds, wheelchairs, crutches and walkers. Notify the Plan immediately at 1-800/433-NALC when durable medical equipment has been prescribed and the anticipated purchase price or rental charges of an item exceed $1,000.

What is not covered

- DME replacements provided less than 3 years after the last one for which benefits were paid
- 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"; computer switch boards or environmental control units; heating pads; air conditioners, purifiers and humidifiers; stair climbing equipment; stair glides; ramps, elevators and other modifications or alterations to vehicles or households and other items (wigs) that do not meet the definition of durable medical equipment on page 29.

Routine services

In addition to coverage of diagnostic X-rays, laboratory and pathology services and machine diagnostic tests, the following routine (screening) services are covered as preventive care.

Blood lead level screening

Annual coverage of one blood lead level test

Other Medical Benefits *continued*

Breast cancer screening

Mammograms are covered for women age 35 and older as follows:

- From age 35 through 39, one mammogram screening during this five year period;
- From age 40 through 64, one mammogram screening every calendar year; and
- At age 65 and older, one mammogram screening every two consecutive calendar years.

Cervical cancer screening

See Pap smears under Additional Benefits, page 18

Colorectal cancer screening

Annual coverage of one fecal occult blood test for members age 40 and older

Prostate cancer screening

Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older

Blood cholesterol screening

Total blood cholesterol test, every three years, between the ages of 19 and 64

Tetanus-diphtheria immunization

Tetanus-diphtheria (Td) booster, every 10 years, between the ages of 19 and over (except as provided for under *Childhood immunizations* on page 18)

Influenza/ Pneumococcal vaccines

Influenza and pneumococcal vaccines, annually, age 65 and over

Strabismus/ Amblyopia eye exam

Eye exam for amblyopia and strabismus, once, between the ages of 2 and 6

Limited benefits

Growth hormone therapy

Growth hormone therapy (GHT) is covered only when preauthorization is obtained through the Plan. Call 1-800/433-NALC for preauthorization. If no preauthorization is obtained before treatment is begun, GHT services will be covered only from the date that information is submitted to the Plan that establishes the medical necessity for GHT. If the Plan determines that GHT is not medically necessary, the related services and supplies for GHT will not be covered.

Hospice care

What is covered

- The Plan will pay up to $3,000 per lifetime for inpatient and outpatient services administered as part of a Hospice care program (see Definitions)

What is not covered

- Independent nursing, homemaker or bereavement services

Rehabilitative therapy

The Plan will pay for up to 90 visits per calendar year for the services of each of the following: qualified physical, speech and occupational therapists. Visits to restore an attained bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury will be covered when the following conditions are met: 1) the care is ordered by the attending doctor; 2) the doctor identifies the specific professional skills required by the patient and the medical necessity for skilled services; and 3) the doctor indicates the length of time the services are needed.

Smoking cessation benefit

After satisfaction of the calendar year deductible, the Plan will pay up to $100 for enrollment in one smoking cessation program per member per lifetime for all related expenses, including drugs.

What is not covered

- Orthopedic shoes, foot orthotics, arch supports, elastic stockings, lumbosacral supports, corsets, trusses and other supportive devices
- Injections of silicone, collagens and similar substances and all related charges
- Eyeglasses, hearing aids and examinations for them (except as covered on page 16), orthoptics (visual training) and eye exercises
- Routine physical checkups and related tests, routine eye and hearing examinations, immunizations and well child care (except as listed above or covered under Additional Benefits)
- Treatment of weak, strained or flat feet; of bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)
- Services by chiropractors, except in those states designated as medically underserved areas (see page 5)
- Chelation therapy, except for acute arsenic, gold, lead or mercury poisoning
- Maintenance therapy including cardiac rehabilitation and exercise programs

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.

Additional Benefits

Accidental injury

The Plan will pay **100%** of the PPO negotiated rate or **100%** of reasonable and customary outpatient charges for nonsurgical services and supplies by a doctor, and for related outpatient hospital services, incurred within 48 hours after an accidental injury, for treatment of that injury. Charges incurred after 48 hours will be considered under Other Medical Benefits.

Childhood immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered at **100%** of reasonable and customary charges for dependent children age 3 to 22. The office visit on the day of the immunization is covered under Other Medical Benefits.

Pap smears

The Plan will pay up to **$35** per test. Charges in excess of **$35** and the office visit charge on the same day will be considered under Other Medical Benefits.

Skilled nursing care

What is covered

The Plan pays **80%** of charges up to a maximum payment of $75 per day for up to 90 days per calendar year of skilled nursing care at home. Charges of a registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) are covered only when:

1) the care is ordered by the attending doctor;
2) the doctor identifies the specific professional skills required by the patient and the medical necessity for skilled services; and
3) the doctor indicates the length of time the services are needed.

What is 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.

Skilled nursing facility (SNF)

Plan pays for semiprivate room, board, services and supplies in a SNF up to a maximum of 30 days per confinement (except for mental conditions) when: 1) the patient is admitted directly from a precertified hospital confinement of at least 3 consecutive days, 2) admission is for the same condition as the hospital confinement and is under the supervision of a doctor, 3) skilled nursing care is provided by an R.N., L.P.N., or L.V.N., and 4) confinement is medically appropriate. No admission deductible applies.

PPO benefit

Plan pays room, board and other charges at **100%** when admission is to a PPO facility; see page 5.

Non-PPO benefit

Plan pays room and board at **100%** and other charges at **80%** when admission is to a non-PPO facility.

Well child care

The Plan pays **100%** of reasonable and customary charges for routine examinations, immunizations and care for each eligible child to age 3. See Other Medical Benefits for the coverage of the initial newborn exam.

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.

Prescription Drug Benefits

What is covered

Each new enrollee will receive a description of the 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 prescribed by a doctor from either a pharmacy or by mail:

- Drugs and medicines (including those for mental conditions and those administered during a non-covered admission or in a non-covered facility and to assist in smoking cessation) that by Federal law of the United States require a doctor's prescription for their purchase, except as excluded below.

  A Federally-approved generic equivalent will be dispensed if it is available, unless your doctor specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your doctor has not specified the name brand drug, you will be required to pay the difference in cost between the name brand drug and the generic.

  The Plan administers an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your doctor may prescribe a brand drug from a formulary list. This list of brand name drugs is a preferred list of drugs selected to meet patient needs at a lower cost to the Plan. A brochure is available by calling 1-800-933-NALC.
- Insulin
- Needles and syringes for the administration of covered medications

Prescription Drug Benefits *continued*

- Drugs for sexual dysfunction will only be covered when the dysfunction is caused by medically documented organic disease. The maximum dosage dispensed will be limited by protocols established by the Plan.

What is not covered

- Drugs and supplies for cosmetic purposes
- Vitamins, nutrients and food supplements even if prescribed or administered by a doctor
- Nonprescription medicines

From a pharmacy

You may purchase prescription drugs either from retail pharmacies that are part of the Plan's CareSelect Pharmacy Network or from non-Network pharmacies.

Network retail pharmacy

After the $25 calendar year drug deductible ($50 per family) and applicable copayment ($5 generic, $10 name brand drug) has been met, Plan pays **100%** of covered charges. Present your NALC card to the pharmacy with your prescription and pay any applicable deductible and copayment. You may obtain up to a 30-day supply plus one refill for each prescription purchased from a CareSelect Network pharmacy. The CareSelect Network pharmacy files your claim and is reimbursed by the Plan. After one refill, you must obtain a new prescription and submit it to the mail order program. Note: Failure to do so will result in benefits payable at the non-Network retail pharmacy benefit level.

Non-network retail pharmacy

After the $25 calendar year drug deductible ($50 per family) has been met, Plan pays **60%** and you pay 40% of covered charges for up to a 30-day supply and unlimited refills. You will need to file a claim for reimbursement.

By mail

You may order up to a 90-day (21-day minimum) supply of medications for a $12 copayment for a generic drug, $25 copayment for a name brand drug, per prescription or refill. No deductible applies. Allow two weeks for delivery. Please note that medications dispensed through the mail order program are subject to the following standards: the professional judgement of the pharmacist, limitations imposed on controlled substances, manufacturer's recommendations, and applicable state law. In most cases, refills cannot be obtained until 75% of the drug has been used. Use the NALC mail order form/patient profile and preaddressed envelope with your first order. Mail these, with your prescription(s) and a check for $12 per generic or $25 per name brand for each prescription or refill, to:

NALC Prescription Drug Program
P.O. Box 380
Lincolnshire, IL 60069-0380

Waivers

The following waivers apply if you have Medicare Part B and Medicare is the primary carrier. If you purchase your prescriptions from CareSelect Network retail pharmacies, your deductible will be waived and your copayments will be $1 per generic and $2 per name brand drug (see Network retail pharmacy above). If you purchase your prescriptions from non-Network retail pharmacies, however, only your calendar year deductible will be waived. If you order by mail, your copayments will be $2 per generic and $4 per name brand drug and no deductible will apply.

To claim benefits

When you use a non-Network pharmacy or you use a CareSelect Network pharmacy and are unable to use your card, complete the Short-Term Prescription claim form and mail with your prescription receipts to:

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

Receipts must specify the prescription number, name of drug, prescribing doctor's name, date, charge and name of drugstore.

Double coverage

When there is double coverage and the other carrier is primary, use that carrier's drug benefit first and call 1-800/933-NALC to request a Short-Term claim form. After the primary carrier has processed the claim, complete the claim form, attach the drug receipts and the other carrier's Explanation of Benefits form, and mail to:

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

Questions?

If you have any questions about the Program, wish to locate a CareSelect Network retail pharmacy, or need additional claim forms call 1-800/933-NALC (8:30 a.m. - 10:00 p.m. Mon. - Fri.; 9:00 a.m. - 1:00 p.m. Sat., Eastern time).

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.

How to Claim Benefits

Claim forms, identification cards and questions

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier at 1-800/433-NALC to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you have a question concerning Plan benefits, contact the Carrier at 703/729-4677 or you may write to the Carrier at 20547 Waverly Court, Ashburn, VA 20149-0001.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with providers.

How to file claims

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA-1500, Health Insurance Claim Form. Claims submitted by enrollees may be submitted on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee
- Plan identification number of the enrollee
- Name and address of person or firm providing the service or supply
- Dates that services or supplies were furnished
- Type of each service or supply (CPT/HCPCS Code) and the charge
- Diagnosis (ICD-9 Code)

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

Cancelled checks, cash register receipts or balance due statements are not acceptable.

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. **Phone 703/729-4677**

See pages 18-19 for instructions on filing prescription drug claims.

Verification of benefits is valid only when provided by the NALC Health Benefit Plan at the above address.

Hospitals may call **1-800/548-8454** for confirmation of benefits.

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. The Carrier will not provide duplicate or year end statements.

Submit claims promptly

The Carrier will not pay benefits for claims submitted more than 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. To avoid denial of payment, submit claims on a timely basis. Once benefits have been paid, there is a three year limitation on the reissuance of uncashed checks.

Direct payment to hospital or provider of care

Other Medical Benefits (subject to the deductible) may not ordinarily be assigned but will be paid directly to the enrollee. Use the Claim Form for Unassigned Bills (CF-2) for filing.

Hospital benefits—To authorize direct payment to a hospital, present your identification card upon admission and complete the hospital's standard authorization/assignment of benefits form or the NALC Hospital Claim Form (H-1).

Doctor benefits—To authorize direct payment to a doctor or surgeon, complete Form HCFA 1500 (Health Insurance Claim Form) available through your provider's office.

When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available. The Carrier, its medical staff and/or an independent medical review, determines whether services, supplies and charges meet the coverage requirements of the Carrier (subject to the disputed claims procedure described on page 21). The Carrier is also entitled to obtain medical or other information, including an independent medical examination, that it may in its discretion consider useful to determine if a service or supply is covered.

Confidentiality

Medical and other information provided to the Carrier, including claim files, is kept confidential and will be used only: 1) by the Carrier and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education. As part of its' administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

Disputed claims review

Reconsideration

If a claim for payment is denied by the Carrier, you must ask the Carrier, in writing and, within six months of the date of the denial, to reconsider its decision before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Carrier an opportunity to reconsider your claim. Before you ask the Carrier to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did they use the correct procedure code for the service(s) performed (surgery, laboratory test, X-ray, office visit, etc.)? Indicate any complications of any surgical procedure(s) performed. Include copies of an operative or procedure report, or other documentation that supports your claim. Your written request to the Carrier must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment should have been paid.

Within 30 days after receipt of your request for reconsideration, the Carrier must affirm the denial in writing to you, pay the claim, or request additional information that is reasonably necessary to make a determination. If the Carrier asks a provider for information it will send you a copy of this request at the same time. The Carrier has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Carrier will base its decision on the information it has on hand.

OPM review

If the Carrier affirms its denial, you have the right to request a review by OPM to determine whether the Carrier's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Carrier's letter affirming its initial denial.

You may also ask OPM for a review if the Carrier fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Carrier. In this case, OPM must receive a request for review within 120 days of your request to the Carrier for reconsideration or of the date you were notified that the Carrier needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the Carrier should have paid the denied claim. If the Carrier has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Carrier requesting reconsideration;
- A copy of the Carrier's reconsideration decision (if the Carrier failed to respond, provide instead (a) the date of your request to the Carrier, or (b) the dates the Carrier requested and you provided additional information to the Carrier);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical record, explanation of benefits (EOB) forms**)**; and
- Your daytime phone number.

Medical documents received from you or the Carrier during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act. Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, P. O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before the OPM when it rendered its decision affirming the Carrier's denial of benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement—If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of the OPM's decision on this disputed claim.

Protection Against Catastrophic Costs

Catastrophic protection

For those services with coinsurance, the Plan pays 100% of reasonable and customary charges for the remainder of the calendar year after covered out-of-pocket expenses under Inpatient Hospital, Surgical, Maternity, Other Medical Benefits and Additional Benefits (Skilled nursing facility only) total $3,500 per individual or $3,500 per family. Out-of-pocket expenses for the purposes of this benefit are:

- The 20% you pay under Non-PPO Inpatient Hospital Benefits;
- The 30% (15% PPO) you pay under Surgical Benefits;
- The 30% (20% PPO) you pay under Other Medical Benefits; and
- The 20% you pay under Additional Benefits for care in a skilled nursing facility.

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

- All deductibles
- Expenses incurred under Additional Benefits for skilled nursing care;
- Expenses incurred under Prescription Drug Benefits;
- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- The $15 copayment for a PPO doctor's office visit charge;
- Expenses for mental conditions or substance abuse; and
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 10, 14, 15, 24).

PPO providers

When your eligible out-of-pocket expenses, as discussed above, from using PPO providers exceed $3,000 per individual or $3,000 per family, the Plan pays 100% of its covered PPO charges for covered services when you continue to select PPO providers for the remainder of the calendar year. Whether or not you use PPO providers, your share of out-of-pocket expenses will not exceed $3,500 per individual or $3,500 per family in a calendar year.

Mental Conditions Benefit

The Plan pays 100% of covered charges for the remainder of the calendar year, after coinsurance out-of-pocket expenses for inpatient mental conditions care total $8,000, not to exceed the calendar year maximum of 50 days.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the covered out-of-pocket maximum expense level in full, your old plan's catastrophic protection benefit will continue to apply until the effective date. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan, you can obtain it by calling the Carrier at 703/729-4677 or you may write the Carrier at 20547 Waverly Court, Ashburn, VA 20149-0001.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Precertification

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. **It is your responsibility to ensure that precertification is obtained.** If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500.

To precertify a scheduled admission:

- You, your representative, your doctor, or your hospital must call the Carrier prior to admission. The toll-free number is 1-800/622-6252.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

A review coordinator will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Carrier's certification decision will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Need additional days?

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional inpatient days are medically necessary. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Carrier will not pay for charges incurred on any extra days that are not determined to be medically necessary by the Carrier during the claim review.

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 24-26). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using the lifetime reserve days.
- You are confined in a hospital outside the United States and Puerto Rico.
- The discharge for your maternity admission is within 48 hours after a regular (routine) delivery or within 96 hours after a cesarean delivery.

Maternity or emergency admissions

When there is an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 1-800/622-6252 **within two business days following the day of admission,** even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by $500.

Newborn confinements that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued confinement within two business days following the mother's discharge.

Precertification *continued*

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless the Carrier is misled by the information given to it. After the claim is received, the Carrier will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If you do not precertify

If precertification is not obtained before admission to the hospital or after 48 hours after a regular (routine) delivery or 96 hours after a cesarean section delivery (or within two business days following the day of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary, the inpatient hospital benefits will not be paid. However, the medical supplies and services otherwise payable on an outpatient basis will be paid.

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by $500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medical services and supplies otherwise payable on an outpatient basis will be paid.

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare (see page 7).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

The following rules apply to enrollees and their family members who are entitled to benefits from both an FEHB plan and Medicare.

This Plan is primary if:

1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;
3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and that you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section**.**

Medicare is primary if:

1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;

5) You are enrolled in Part B only, regardless of your employment status;

6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);

7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;

8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or

9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

When Medicare is primary

When Medicare is primary, all or part of your Plan deductibles, coinsurance and copayments will be waived as follows:

- **Inpatient Hospital Benefits:** If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.
- **Surgical Benefits:** If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance.
- **Mental Conditions/Substance Abuse Benefits:** If you are enrolled in Medicare Part A, the Plan waives the inpatient deductible and coinsurance for hospital charges. If you are enrolled in Medicare Part B, the Plan waives the deductible and coinsurance for professional services and confinements in treatment facilities. Benefit limits and the calendar year maximum will not be waived.
- **Other Medical Benefits:** If you are enrolled in Medicare Part B, the Plan waives the deductible, coinsurance, and outpatient office visit copayments. The lifetime maximum for hospice care will not be waived.
- **Additional Benefits:** If you are enrolled in Medicare Part B, the Plan waives the coinsurance for skilled nursing care and the skilled nursing facility coinsurance.
- **Prescription Drug Benefits:** If you are enrolled in Medicare Part B, the Plan waives the deductible required for purchases from a network or non-network retail pharmacy. However, the stated copayments or coinsurance for Medicare recipients will not be waived.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its 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.

If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

When you also enroll in a Medicare prepaid plan

When you are enrolled in a Medicare prepaid plan while you are a member of this Plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims.

Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Doctors who participate with Medicare accept assignment; that is, they have agreed not to bill you for more than the **Medicare-approved amount** for covered services. Some doctors who do not participate with Medicare accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid only when the Medicare and Plan payments combined do not total the Medicare-approved amount.

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the **limiting charge,** is 115 percent of the Medicare-approved amount. Under this law, if you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid **only** if the Medicare and Plan payments combined do not total the limiting charge. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. **The Medicare Summary Notice (MSN) will have more information about this limit.**

This Plan and Medicare *continued*

If your doctor does not participate with Medicare, asks you to pay more than the limiting charge **and** he or she is under contract with this Plan, call the Plan. If your doctor is **not** a Plan doctor, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the Medicare Summary Notice. In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115 percent of the Medicare-approved amount.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. Your provider should submit your claims to Medicare and, after Medicare has paid its benefits, this Plan will consider the balance of any covered expenses. This Plan has contracted with Medicare Part B carriers to receive electronic copies of your claims after Medicare has paid their benefits. This eliminates the need for you to submit your Part B claims to this Plan. Your copy of the Plan's explanation of benefits will indicate if your claims are being filed electronically. If they are not, you must submit the Medicare Summary Notice with duplicates of all bills and a completed claim form. This Plan will not process your claim until the Medicare Summary Notice is received.

Enrollment Information

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How to claim benefits" on page 20.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system (see *"Effective date"* on page 29). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see "If you are hospitalized" below.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The **benefits** in this brochure are effective on January 1 for those already enrolled in this Plan. If you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new **rates** are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).

- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.
- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Carrier promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

  Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

  You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 25 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

  Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she will generally be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36-month period noted above.

Notification and election requirements:

- **Separating employees —** Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.
- **Children —** You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.
- **Former spouses —** You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

  The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices is available — or chosen — when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Definitions

Accidental injury

A bodily injury sustained solely through violent, external and accidental means.

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 the same day.

Assignment

An authorization by an enrollee or spouse for the Carrier to issue payment of benefits directly to the provider. The Carrier reserves the right to pay the member 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 existing at or from birth which 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 structures supporting the teeth.

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.

Custodial care

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

1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
2) homemaking, such as preparing meals or special diets;
3) moving the patient;
4) acting as companion or sitter;
5) supervising medication that can usually be self administered; or
6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Plan determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

1) are prescribed by your attending doctor;
2) are medically necessary;
3) are primarily and customarily used only for a medical purpose;
4) are generally useful only to a person with an illness or injury;
5) are designed for prolonged use; and
6) serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

The date the benefits described in this brochure are effective:

1) January 1 for continuing enrollments and for all annuitant enrollments;
2) 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 for the first time; or
3) for new enrollees during the calendar year, but not during the open season, the effective date of enrollment as determined by the employing office or retirement system.

Experimental or investigational

A drug, device or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully 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.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

If you wish to obtain information concerning the experimental/investigational determination process, please contact the Plan.

Group health coverage

Health care coverage that a member is eligible for because of employment, membership in, or connection with a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.

Hospice care program

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.

Incurred date

The date when the service or supply is received. The benefits that apply are those in effect on the date the charge is incurred.

Medically necessary

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

1) are appropriate to diagnose or treat the patient's condition, illness or injury;
2) are consistent with standards of good medical practice in the United States;
3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4) are not a part of or associated with the scholastic education or vocational training of the patient; and
5) 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 conditions/ 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.

Morbid obesity

A condition wherein an individual: 1) is the greater of 100 pounds or 100% over normal weight with complicating medical conditions; and 2) has been so despite documented attempts to reduce using a doctor-monitored diet and exercise program.

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.

Reasonable and customary

The benefits of this Plan are limited to, and based on, reasonable and customary charges, except for negotiated rates with PPO providers, Network retail pharmacies and mail order pharmacies. The reasonable and customary charge for any service or supply is 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. The Plan determines reasonable and customary charges for inpatient and outpatient Surgical Benefits from data prepared by the Health Insurance Association of America (HIAA). For physician and other professional services and laboratory and X-ray procedures under Other Medical Benefits, the Plan uses data prepared by Medical Data Research (MDR). The Plan pays claims based on the 90th percentile for HIAA 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 reasonable and customary may exist.

Index

Abortion – 9
Accidental injury – 18, 29
Acupuncture – 16
Additional Benefits – 18
Admission – 10, 14, 15, 23, 24, 29
Alcoholism – 15
Allergy tests & injectable antigens – 16
Allogeneic bone marrow transplant – 12
Ambulance – 9, 10, 16
Anesthesia – 10, 11, 12, 16
Anesthesiologist – 11
Appliances – 16
Artificial insemination – 14
Artificial limbs & eyes – 16
Artificial organs – 12
Assignment – 29
Assistant surgeon – 11
Assisted reproductive technology (ART) – 14
Attending doctor – 16
Audits – 21
Autologous bone marrow transplant (ABMT) – 12
Autologous peripheral stem cell support – 12
Automobile insurance – 7

Bilateral surgical procedures – 11
Birthing center – 4, 14
Blood & blood plasma – 10, 16
Blood lead level screening – 16
Bone marrow transplant – 12
Braces – 16
Breast cancer screening – 17
Breast prosthesis – 10, 16

Calendar year deductible – 6, 11, 14, 15, 16, 19, 29
Cancer screening (Pap smear) – 17, 18
Carryover – 6, 22
Catastrophic Protection – 22
Cervical cancer screening (Pap smear) – 17, 18
CHAMPUS – 7
Charges, reasonable & customary – 30
Chelation therapy – 17
Chemotherapy/radiation therapy – 16
Claim forms – 20
Claiming benefits – 20
Cleft palate/lip – 12
Clinical psychologist/social worker – 5
Coinsurance – 6
Colorectal cancer screening – 17
Community mental health organization – 5
Confidentiality – 21
Congenital anomaly – 13, 29
Consultations – 16
Continuation of coverage, temporary (TCC) – 27
Contraceptive implants & devices – 14
Conversion – 28
Coordination of benefits – 7
Copayment – 6, 16, 19
Cosmetic surgery – 29
Cost Sharing – 6
Counselors – 15
Covered facilities/providers – 4, 5
Crutches – 16
Custodial care – 9, 29

Days certified – 23
Deductible – 6, 10, 11, 12, 14, 15, 16, 19
Definitions – 29, 30
Diabetic supplies & insulin – 16, 18
Diagnostic tests – 10, 14, 16
Dialysis – 16
Disputed claims – 21, 22
Doctor – 4, 5, 11, 12, 14, 15, 16
Donor expenses – 12
Double coverage – 7
Drugs & medicines – 18, 19
Durable medical equipment (DME) – 16, 29

Effective date – 5, 26, 29
Embryo transfer – 14
Emergency admission – 10, 14, 15, 23, 24
Employee Express – 26
Enrollment Information – 26, 27, 28
Equipment, durable medical (DME) – 16, 29
Exclusions – 9, 11, 12, 13, 14, 15, 16, 17, 19
Exercise equipment – 16
Experimental/investigational drug/device/treatment – 9, 29, 30
Extended care facility – 4, 11
External breast prosthesis – 16
Eye examination – 17
Eyeglasses – 16, 17

Facilities & Providers – 4
Facility, treatment – 4, 15
Family limit – 6
Fecal occult blood test – 17
Flexible benefits option – 4
Former spouse coverage – 27, 28
Fraud – 2

Gamete intrafallopian transfer (GIFT) – 14
Gastric bypass – 11
General Exclusions – 9
General Limitations – 7, 8
Genetic counseling – 14
Group B streptococcus infection – 14
Group health coverage – 7, 30
Growth hormone – 9, 17

Halfway house – 11, 15
Hearing aid & examination – 16
Heating lamp/pad – 16
Hemodialysis – 16
Home & office visits – 16
Home IV therapy – 16
Home nursing care – 18
Hospice care – 17, 30
Hospital – 4
Hospital admissions – 10, 14, 15, 23, 24
Hospital bassinet/nursery – 14
Hospital inpatient benefits – 10, 11
Humidifiers – 16

Identification cards – 26
Immunizations – 18
Implants – 12,13
In vitro fertilization – 14
Incidental procedures – 11
Incurred date – 30
Infertility – 14
Information you have a right to know – 23
Injectables – 16
Inpatient Hospital Benefits – 10, 11
Inspector General Advisory (fraud) – 2
Insulin & diabetic supplies – 16, 18
Intensive care unit – 10
Intra-ocular surgery – 16
Investigational/experimental treatment – 9, 29, 30
Itemized bills – 20
IV therapy – 16

Keratoplasty – 13
Keratotomy – 13

Index *continued*

Kidney transplant – 12

Laboratory tests – 10, 14, 16
Laws, Federal – 6, 7, 8, 21, 22, 24, 25
Learning disabilities – 15
Licensed practical nurse (L.P.N.) – 18
Licensed vocational nurse (L.V.N.) – 18
Lifetime maximum – 6, 15, 17
Limb, artificial – 16
Limitations – 7, 8
Liver transplant – 12
Lung transplant – 12

Machine diagnostic tests – 16
Mail order prescription drug program – 18, 19
Mammogram screening – 17
Mastectomy – 10, 13
Maternity Benefits – 14
Maxillofacial surgery – 12
Maximum limiting charge – 25, 26
Maximums – 6, 15, 17
Medicaid – 7
Medical equipment, durable (DME) – 16
Medically necessary – 30
Medically underserved areas (MUA) – 5
Medicare – 24, 25, 26
Medicare, 65 and over, no Medicare – 8
Medicare waiver – 10, 25
Medicines – 10, 18, 19
Mental Conditions/Substance Abuse Benefits – 15, 30
Midwife – 14
Morbid obesity – 11, 30
Multiple or bilateral surgical procedures – 11

National Transplant Program – 12
Needles & syringes – 16, 18
Negotiated rate – 5
Network retail pharmacy – 19
Newborn examination – 16
No-fault automobile insurance – 7
Non-FEHB Benefits – 33
Non-network retail pharmacy – 19
Non-PPO provider – 5, 11, 13, 14, 15, 17, 18, 19
Nongroup Plan – 28,
Nonprescription medicine – 19
Nonsurgical treatment – 9, 16
Nurse anesthetist(C.R.N.A.) – 5
Nurse midwife – 5, 14
Nurse practitioner/clinical specialist – 5
Nurses, R.N./L.P.N./L.V.N. – 18
Nursing facility, skilled (SNF) – 4, 18
Nursing home – 4, 11
Nursing school administered clinic – 5

Obesity – 9, 11
Obstetrical care – 14
Occupational therapist – 17
Ocular injury – 16
Optometrist – 5
Oral & maxillofacial surgery – 12
Oral implants & transplants – 13
Organ/tissue transplants – 12
Ostomy & catheter supplies – 16
Other Medical Benefits – 16, 17
Out-of-pocket expenses – 22
Outpatient care – 14, 15, 16
Outpatient surgery – 11
Overpayments – 8
Oxygen – 10, 16

Pap smear – 18
Pathologist – 11
Per admission deductible – 6, 10, 15
Peritoneal dialysis – 16
Personal comfort items – 11
Physical therapist – 17
Podiatrist – 4
Practical nurse (L.P.N.) – 18
Pre-admission testing – 10, 30
Precertification – 10, 14, 15, 23, 24
Preferred provider
organization (PPO) – 4, 5, 6, 8, 10, 11, 12, 14, 15, 16, 18, 22
Prescription Drug Benefits – 18, 19
Preventive care – 16, 17, 18
Primary payer – 7, 24, 25, 26
Privacy Act statement – 22
Private duty nursing – 11, 18
Private room – 10
Professional charges – 11
Prostate cancer screening – 17
Prostate specific antigen (PSA) – 17
Protection Against Catastrophic Costs – 22
Providers, covered – 4
Psychologist – 5

Qualified clinical psychologist – 5
Qualified occupational, physical & speech therapist – 17

Radiation therapy – 16
Radiologist – 11
Reasonable & customary – 30
Registered nurse (R.N.) – 18
Rental, equipment – 16
Residential treatment center – 11, 15
Reversal of surgical sterilization – 13
Room & board – 10, 11, 14, 18
Routine physical exam – 17
Routine services – 16, 17

Schools – 11, 15
Screenings – 16, 17
Second surgical opinions – 11, 16
Semiprivate accommodation – 10, 14, 15, 18
Skilled nursing care – 18
Skilled nursing facility (SNF) – 4, 18
Smoking cessation benefit – 17
Sonogram – 14
Spouse coverage, former – 27, 28
Speech therapist – 17
Standby physicians & surgeons – 9, 13
Sterilization – 11, 13
Subrogation provision – 7
Substance Abuse Benefits – 15
Summary of Benefits – 35
Surcharge – 11
Surgical Benefits – 11, 12, 13

Table of Contents – 3
Temporary continuation of coverage (TCC) – 27, 28
Temporomandibular disorders – 21
Tests – 9, 10, 14, 16, 17
Transplant, organ/tissue – 12
Treatment facility – 4, 15

Veterans Affairs – 7
Vitamins – 19
Vocational nurse (L.V.N.) – 18

Waivers – 10, 19, 26
Walker – 16
Weight reduction – 9
Well child care – 18
Wheelchair – 16
Workers' compensation – 7

X-rays – 10

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copayment charges, etc. These benefits are not subject to the FEHB disputed claims procedure.

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 $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 $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 life—you 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 1-800/424-5184 Tuesdays and Thursdays, 8:00 a.m. - 3:30 p.m. EST.

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

How NALC Health Benefit Plan Changes January 1999

Do not rely entirely on this page; it is not a complete statement of benefits. Please review the official brochure in its entirety.

Program-wide Changes

- The medical management of mental conditions will be covered under this Plan's Other Medical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 30 outpatient Mental Conditions visit limit.
- The definition of experimental or investigational (see pages 29-30) has been clarified to include biological products.
- If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services by this Plan.
- The States designated as medically underserved have changed for 1999. Idaho and North Dakota have been added, and West Virginia is no longer underserved. See page 5 for information on medically underserved areas.

Changes to this Plan

- The calendar year deductible has been decreased from $350 to $275 per year per person (up to a $550 family limit) applicable to Other Medical Benefits, Surgical Benefits, and Maternity Benefits.
- The members' family out-of-pocket expenses under the Catastrophic Protection Benefit has been decreased as follows:

  Under PPO benefits: from $6,000 to $3,000 per family.

  Under Non-PPO benefits: from $7,000 to $3,500 per family.
- The Plan's rate of reimbursement for PPO providers under Surgical Benefits has been increased from 80% to 85% of the negotiated rate.

Summary of Benefits for the NALC Health Benefit Plan — 1999

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the **$275** calendar year deductible.

Benefits		Plan pays/provides	Page
Inpatient care	**Hospital**	**PPO benefit: 100%** of room, board and other charges, no deductible **Non-PPO benefit:** After a $100 deductible per admission; **80%** for ward or semiprivate accommodations; **80%** of other hospital charges	10 - 11
	Surgical	**PPO benefit: 85%*** of the surgeon's negotiated rate **Non-PPO benefit: 70%*** of reasonable and customary charges	11 - 13
	Medical	**PPO benefit: 80%*** of the doctor's negotiated rate **Non-PPO benefit: 70%*** of the doctor's reasonable and customary charges	16 - 17
	Maternity	Same benefits as for illness or injury	14
	Mental Conditions/ Substance Abuse		
	Mental Conditions	**PPO benefit:** After a $400 deductible, **50%** of PPO hospital charges up to a maximum of 50 days per year **Non-PPO benefit:** After a $500 deductible per admission, **50%** for ward or semiprivate accommodations and other hospital charges, up to a maximum of 50 days per year	15
	Substance Abuse	After a separate $250 calendar year Substance Abuse deductible, **50%** of charges for up to 30 days of care while confined in a treatment facility, per lifetime	15
Outpatient care	**Hospital**	**PPO benefit: 80%*** of the negotiated rate **Non-PPO benefit: 70%*** of reasonable and customary charges	16 - 17
	Surgical	**PPO benefit: 85%*** of the surgeon's negotiated rate **Non-PPO benefit: 70%*** of reasonable and customary charges related to and on the day of surgery	11 - 13
	Medical	**PPO benefit:** $15 copay per covered office visit; other benefits, **80%*** of the negotiated rate **Non-PPO benefit: 70%*** of reasonable and customary charge for outpatient physician office visits; **70%*** of reasonable and customary charges for other medical services	16 - 17
	Maternity	Same benefits as for illness or injury	14
	Home Health Care	No current benefit	
	Mental Conditions/ Substance Abuse	**PPO benefit:** After satisfaction of a $250 calendar year deductible, **60%** of charges for 30 visits per year. **Non-PPO benefit:** After satisfaction of a $250 calendar year deductible, **50%** of charges for 30 visits per year	15
Emergency care (accidental injury)		**100%** for nonsurgical outpatient services and supplies for care of injury when incurred within 48 hours after accident; charges incurred after 48 hours are considered as Other Medical Benefits	18
Prescription drugs		Pharmacy: From a Network retail pharmacy (after the $25 per individual/$50 per family prescription drug deductible) you pay a copayment of $5 per generic, $10 per name brand per prescription or refill. From a non-Network pharmacy, after the $25 per individual/$50 family drug deductible, you pay 40% (the Plan pays **60%**) of covered charges	18 - 19
		Mail order: You pay a copayment of $12 generic and $25 name brand per prescription or refill	18 - 19
Dental care		No current benefit	
Additional benefits		Childhood immunizations, Pap smears, Skilled nursing care, Skilled nursing facility, Well child care	18
Protection against catastrophic costs		**PPO benefit:** Plan pays **100%** when PPO out-of-pocket expenses for Inpatient Hospital, Surgical, Maternity and Other Medical Benefits total more than **$3,000** per individual or **$3,000** per family.	22
		Non-PPO benefit: Plan pays **100%** when non-PPO out-of-pocket expenses for Inpatient Hospital, Surgical, Maternity, Other Medical Benefits and Additional Benefits (Skilled nursing facility only) total more than **$3,500** per individual or **$3,500** per family. Whether or not you use PPO providers, your share of out-of-pocket expenses will not exceed **$3,500** per individual or **$3,500** per family in a calendar year.	22
	Mental Conditions	The Plan pays **100%** when out-of-pocket expenses (50% coinsurance) for inpatient mental conditions reach $8,000 per person in a calendar year, but not to exceed the 50-day calendar year maximum.	22

1999 Rate Information for
NALC Health Benefit Plan

FEHB Benefits of this Plan are described in this brochure (71-9).

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, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		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
Self Only	321	$ 72.06	$43.14	$156.13	$ 93.47	$ 84.98	$30.22
Self and Family	322	$160.39	$85.79	$347.51	$185.88	$183.29	$62.89