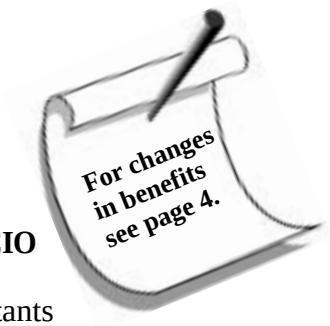
NALC Health Benefit Plan

2000

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 Retirement and Insurance

Federal Employees Health Benefits Program

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Table of Contents

Introduction

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

This brochure describes the benefits you can receive from The NALC Health Benefit Plan under its contract CS1067 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. Nothing anyone says can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

Because OPM negotiates benefits and premiums annually they change each year. This brochure describes the only benefits available to you under this Plan in 2000. Benefit changes are effective January 1, 2000, and are shown on page 4. You do not have a right to benefits that were available before January 1, 2000 unless those benefits are also contained in this brochure. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to The NALC Health Benefit Plan as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

Sections one, two, four, and ten are now in plain language, as well as portions of sections three and eight. We will rewrite the remaining sections of this brochure, including the benefits section, for year 2001. Please note that the format and organization of this brochure have changed as well.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

How to use this brochure

This brochure has ten sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Fee-for-Service Plans (FFS). This Plan is a FFS Plan. Turn to this section for a brief description of Fee-for-Service plans and how they work.
2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.
3. How to get benefits. Make sure you read this section; it tells you how to get benefits and how we operate.
4. What if we deny your claim or request for coverage or pre-authorization? This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for coverage or pre-authorization.
5. BENEFITS. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. How to file a claim. Look here to find specific information on how to file claims with us.
7. General exclusions – Things we don't cover. Look here to see things that we will not cover.
8. Limitations – Rules that affect your benefits. This section describes limits that can affect your benefits, such as Medicare, other group insurance and third party liability.
9. Fee-for-Service Facts. This section contains information about pre-certification, protection against catastrophic expenses, and a definition section.
10. FEHB FACTS. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Fee-for-Service Plans

Fee-for-Service plans reimburse you or your provider for covered services. They do not typically provide or arrange for health care. Fee-for-Service plans let you choose your own physicians, hospitals, and other health care providers.

The FFS plans reimburse you for your health care expenses, usually on a percentage basis. These percentages, as well as deductibles, methods for applying deductibles to families, and the percentage of coinsurance you must pay vary by plan. The type and extent of covered services varies by plan. There is a detailed explanation of the benefits we offer in this brochure; you should read it carefully.

This FFS plan offers a preferred provider organization (PPO) arrangement with The **First Health**® Network. This arrangement with health care providers gives you enhanced benefits or limits your out-of-pocket expenses.

Section 2. How we change for 2000

Program-wide changes

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition or are in the second or third trimester of pregnancy, and your provider is leaving our PPO network at our request without cause, we will notify you. You may continue to receive our PPO level benefits for your specialist's services for up to 90 days after you receive notice. We will provide regular non-PPO benefits for the specialist's services after the 90 day period expires.

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Three states are added to the list of medically underserved areas; they are: Kentucky, Missouri and Utah.

Changes to this Plan

- Your share of the NALC Postal A premium will increase by 8.0% for Self Only or –3.2% for Self and Family.
- Your share of the NALC Postal B premium will increase by 7.3% for Self Only or 7.5% for Self and Family.
- Your share of the NALC non-Postal premium will increase by 8.6% for Self Only or 8.0% for Self and Family.
- The Plan's rate of reimbursement for PPO providers for inpatient professional care and outpatient hospital and medical care is increased to 85% of the negotiated rate (from 80%).
- Member copayments for routine services by a PPO provider (listed on page 16) now range from $5 to $25 per service.
- The member's copayment for each allergy injection by a PPO provider is now $5.
- A toll-free 24-hour nurse health resource line is available, 7 days a week, to answer your health care concerns.
- Arrangements for discounted rates for your purchase or rental of durable medical equipment (DME) are available. Contact the Plan immediately when DME is prescribed.
- Member copayments for PPO providers are not counted toward your out-of-pocket expenses limit under the catastrophic protection provision.
- Prior Plan authorization is required for the purchase of certain drugs. The Plan may limit the maximum dosage dispensed by protocols set by the Plan.

Section 3. How to get benefits

How do I keep my health care expenses down?

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 page 26 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.

Section 3. How to get benefits *continued*

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.

How much do I pay for services?

You must share the cost of some services. These cost sharing measures include deductibles, coinsurance and copayments. These and other measures are described in more detail below.

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; 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 14).

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 85% 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 26), 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).

Section 3. How to get benefits *continued*

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.

Do I have to submit claims?

You usually do not have to submit claims to us if you use preferred providers. If you file a claim, please send us all of the documents for your claim as soon as possible. Claims must be received by us within two years of the date of service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Please see Section 6, How to file a claim, for specific information you need to know before you file a claim with us.

Who provides my health care?

In a Fee-for-Service Plan, you may choose any covered facility or provider.

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 2000, the States designated as medically underserved are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, South Carolina, South Dakota, Utah 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.

Section 3. How to get benefits *continued*

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 (http://www.nalc.org/hbp), 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. When you choose a PPO provider, the Plan pays 100% of the negotiated rate after you pay a copayment per service, such as allergy injection $5, office visit $15 and specific routine services from $5 to $25 as listed on page 16. Other services by PPO doctors and health care professionals are paid at 85% 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.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 703/729-4677. If you are new to the FEHB Program, we will reimburse your covered expenses. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center, or
- You exhaust the benefits available from your former plan, or
- The 92nd day after you became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

What if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. If it is, you may be able to continue seeing your provider for up to 90 days after you receive notice that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

Section 3. How to get benefits *continued*

If you continue seeing your specialist or OB/GYN under these conditions, your cost will be no more than you would normally pay for the services covered.

How do you decide if a service is experimental or investigational?

Our Medical Director reviews current medical resources to determine if a service or supply is experimental or investigational. An independent expert opinion may be sought by us if necessary.

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.

Section 4. What to do if we deny your claim or request for coverage or pre-authorization?

What should I do before filing a disputed claim?

Before you ask us to reconsider your claim, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did the provider use the correct procedure code for the services performed (surgery, laboratory test, x-ray, office visit, etc.)? Have your provider indicate any complications of any surgical procedures performed. Your provider should also include copies of an operative or procedure report, or other documentation that supports your claim.

If we deny your request for coverage or pre-authorization or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

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

1. Maintain our denial in writing;
2. Pay the claim;
3. Approve your request for coverage or pre-authorization; or
4. Ask for more information.

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for coverage or pre-authorization?

Call us at 703/729-4677 and we will expedite our review.

Section 4. What to do if we deny your claim or request for coverage or pre-authorization? *continued*

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division II at (202) 606-3818 between 8 a.m. and 5 p.m. Eastern time. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

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

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above (as established at section 890.105, title 5, Code of Federal Regulations (CFR)). As required by section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. BENEFITS **Inpatient Hospital Benefits**

All benefits are subject to definitions, limitations, and exclusions in this brochure and are payable when determined by us to be medically necessary.

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 page 26 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 pages 23-24.

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 6.

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 5, 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 an 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 6.

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 6.

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.

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 **85%** of negotiated rate. See page 6.

Non-PPO benefit — Plan pays **70%** of the reasonable and customary charge.

Section 5. BENEFITS **Inpatient Hospital Benefits** *continued*

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 6, 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 28

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.

Section 5. BENEFITS **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 5.

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 reasonable and customary 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 are considered under Other Medical Benefits.

Related benefits

Professional charges
Inpatient: see Professional charges on page 10.
Outpatient services by anesthesiologists, radiologists and pathologists:

PPO benefit
Plan pays **85%** 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:

Section 5. BENEFITS **Surgical Benefits** *continued*

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 The **First Health**, National Transplant Program. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact First Health at 1-800/622-6252 and ask to speak to a Transplant Case Manager. You will be given information about this program including a list of participating 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.

Mastectomy surgery

Benefits will be provided for breast reconstruction surgery following a mastectomy, including surgery to produce a symmetrical appearance on the other breast. Benefits will be provided for all stages of breast reconstruction following a mastectomy, including treatment of any physical complications, including lymphedemas, and for breast prostheses, including surgical bras and replacements.

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.

Screening sigmoidoscopy

The Plan covers one routine screening sigmoidoscopy every 5 years starting at age 50.

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
- Radial keratotomy and other refractive surgery
- Cosmetic surgery (see definition on page 28), 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.

Section 5. BENEFITS **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 page 26 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 6.

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 5, 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
- Genetic counseling

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Section 5. BENEFITS **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 6.

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 5, 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 page 26 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 ancilliary 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 5, 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 page 26 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 the negotiated rate 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 reasonable and customary 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.

Section 5. BENEFITS **Other Medical Benefits**

What is covered The Plan pays for the following services:

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 6), 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 **85%** of the negotiated rate for the following services and supplies provided by a Plan PPO network provider. See page 6.

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 followup 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 (also see Allergy injections below)
- 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
- Durable medical equipment (also see Durable medical equipment below)
- Artificial limbs and eyes; stump hose (also see Durable medical equipment below)
- 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
- Externally worn breast prostheses and surgical bras including necessary replacements 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

Allergy injections Professional services for the administration of allergy serum are payable as follows:

PPO benefit After you pay a $5 copayment, the Plan pays **100%** of the negotiated rate for each allergy injection performed by a PPO provider. See page 6.

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

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 covered are hospital beds, wheelchairs, crutches and walkers. Arrangements have been made with a health care provider for purchase or rental of durable medical equipment at discounted rates. Notify the Plan immediately at 1-800/433-NALC when durable medical equipment has been prescribed.

What is not covered

- DME replacements and prosthetic 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"; enhanced vision systems; 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 28.

Section 5. BENEFITS **Other Medical Benefits** *continued*

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.

PPO benefit

After you pay the applicable copayment shown below, the Plan pays **100%** of the negotiated rate for services performed by a PPO provider. See page 6.

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 provided by a non-PPO provider.

		PPO Copayment
Blood lead level screening	• Annual coverage of one blood lead level test	$5
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;	$25
	• From age 40 through 64, one mammogram screening every calendar year; and	$25
	• At age 65 and older, one mammogram screening every two consecutive calendar years.	$25
Cervical cancer screening	• See Pap smears under Additional Benefits	see page 17
Colorectal cancer screening	• Annual coverage of one fecal occult blood test for members age 40 and older	$5
	• See Screening sigmoidoscopy under Surgical Benefits	see page 12
Prostate cancer screening	• Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older	$25
Blood cholesterol screening	• Total blood cholesterol test, every three years, ages 19 through 64	$5
Tetanus-diphtheria immunization	• Tetanus-diphtheria (Td) booster, every 10 years, age 19 and over (except as provided for under Childhood immunizations on page 17)	$5
Influenza/ Pneumococcal vaccines	• Influenza and pneumococcal vaccines, annually, age 65 and over	$5
Strabismus/ Amblyopia eye exam	• Eye exam for amblyopia and strabismus, once, ages 2 through 6	$15

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 definition page 29)

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

Section 5. BENEFITS **Other Medical Benefits** *continued*

- Eyeglasses, hearing aids and examinations for them (except as covered on page 15), 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 on page 16 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 6)
- Chelation therapy, except for acute arsenic, gold, lead or mercury poisoning
- Maintenance therapy including cardiac rehabilitation and exercise programs

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Section 5. BENEFITS **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 6.

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.

Free 24 hour nurse health resource line

For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-622-6252 and talk with a registered nurse who will discuss treatment options and answer your health questions.

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.

Section 5. BENEFITS **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) 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 name brand drug from a formulary list. This list of name brand 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
- Drugs for sexual dysfunction will only be covered when the dysfunction is caused by medically documented organic disease (see Prior authorization below).

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) has been met, the 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, the 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

Prior authorization

Some drugs require prior authorization. Call the Plan at 1-800-433-NALC for information. Maximum dosage dispensed may be limited by protocols established by the Plan.

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.

Section 5. BENEFITS **Prescription Drug Benefits** *continued*

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.

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 $2,250 a month, $75 a day or up to $1,500 a month, $50 a day or up to $900 a month with the $30 a day plan. Members and their spouses may select these plans. Children's coverages are limited to either $45 a day, $30 a day or $18 a day plans.

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

This plan is available to all qualified members regardless of their age. Hospital Plus is renewable for 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.

Section 6. How to File a Claim

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
- Signature of physician or supplier including degrees or credentials of individual providing the service
- 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.

Section 6. How to File a Claim *continued*

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 pages 8-9). 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.

Section 7. General exclusions – Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness or condition. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not make it medically necessary or eligible for coverage under this Plan.

Exclusions listed with a single benefit category may apply to other categories. Refer to Section 5, BENEFITS, to assure that you are aware of all exclusions.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services, drugs or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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;
- Procedures, services, drugs and supplies related to sex transformations, sexual dysfunction (except as provided on page 18) or sexual inadequacy;
- Services or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses you incurred while you were not enrolled in this Plan;
- Charges that would not be made if a covered individual had no health insurance;
- Services furnished without charge (except as described on page 25), while on active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat;
- Services furnished by household members or immediate relative such as spouse, parent, child, brother or sister by blood, marriage or adoption;
- Charges furnished or billed by a noncovered facility, except medically necessary prescription drugs;
- All services for and related to a procedure not listed as covered;
- Charges furnished or billed by noncovered providers;
- Any portion of a charge, ordinarily due from you such as a deductible, coinsurance and copayment, that has been waived. We will reduce the billed charge by the amount waived;
- Charges for which you or the Plan have 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 26), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 24), or State premium taxes however applied;
- Charges in excess of the reasonable and customary amount;
- Any treatment for cosmetic purposes;
- Custodial care as defined on page 28;
- Injections of growth hormones and related supplies, except when preauthorization has been obtained through the Plan;
- Charges for interest, completion of claim forms, missed or cancelled appointments and administrative fees;
- Nonmedical social services, recreational therapy, training in activities of daily living, educational and training services;
- Nonsurgical treatment for weight reduction or obesity;
- Speech therapy, except as provided on page 16;
- Testing for mental aptitude or scholastic ability;
- Therapy for developmental delays, learning disabilities, stuttering, tongue thrusting or deviate swallowing;
- Transportation or travel (other than ambulance services and travel under the managed transplant system); and
- Dental services and supplies except those oral surgical procedures listed on page 12.

Section 8. Limitations – Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare and this Plan will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office, or call SSA at 1-800/638-6833.

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+Choice 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 25).

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.

Section 8. Limitations – Rules that affect your benefits *continued*

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 + Choice plan

When you are enrolled in a Medicare+Choice 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.**

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.

Section 8. Limitations – Rules that affect your benefits *continued*

Other group insurance coverage

When you have coverage with us and another group health plan or medical coverage with an auto insurance company, that pays health benefits without regard to fault, it is called Double Coverage (Coordination of Benefits). You must send us information about the other insurance if you or a family member has Double Coverage.

When you have Double Coverage, one plan pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We decide which group health plan is primary according to the National Association of Insurance Commissioners Guidelines. When health benefits are payable by auto insurance, the auto insurer is primary if it is legally obligated to provide benefits without regard to other health coverage you have.

If we pay second, we will determine how much of the charge is allowable. After the first plan pays, we will pay either what is left, the allowable charge or our regular benefit, whichever is less. The total payments of all plans will never be more than the allowable charge.

We will apply this provision whether or not a claim is filed with the other plan.

When others are responsible for injuries

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.

TRICARE

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

Workers' compensation

We do not cover services that:

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

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

We are entitled to be reimbursed by OWCP (or similar agency) for benefits paid by us that were later found to be payable by OWCP (or the agency).

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

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.

Section 8. Limitations – Rules that affect your benefits *continued*

Vested rights

An enrollee does not have a vested right to the benefits in this brochure in 2001 or later years, and does not have a right to benefits available prior to 2000 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.

Section 9. Fee-For-Service Facts

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.

Section 9. Fee-For-Service Facts *continued*

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 23-25). 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.

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 an 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.

Protection Against Catastrophic Costs

Catastrophic protection

For those services with coinsurance, the Plan pays 100% (no deductible or coinsurance applies) 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% (15% 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;
- All copayments for PPO providers;
- 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;
- 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 page 4).

Section 9. Fee-For-Service Facts *continued*

PPO providers When your eligible out-of-pocket expenses 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.

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.

Section 9. Fee-For-Service Facts *continued*

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

See page 8.

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 from data prepared by Ingenix, Inc., including both the Prevailing Healthcare Charges System (PHCS) and Medical Data Research (MDR) data. For inpatient and outpatient Surgical Benefits, data is from PHCS. For physician and other professional services and laboratory and X-ray procedures under Other Medical Benefits, the Plan uses data prepared by MDR. The Plan pays claims based on the 90th percentile for both PHCS and MDR. This data is updated twice per year. For other categories of benefits and for certain specific services within each of the above categories, exceptions to the general method of determining reasonable and customary may exist.

Section 10. FEHB FACTS

You have a right to the following information.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website **(www.opm.gov)** lists the specific types of information that we must make available to you.

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

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions, and give you a Guide to Federal Employees Health Benefits Plans, brochures for other plans and other materials you need to make an informed decision about:

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

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

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1. If you are in the hospital on the effective date, see page 7.

What happens when I retire?

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

What types of coverage are available for me and my family?

Self-Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who became incapable of self-support before age 22.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or receive benefits from another FEHB plan.

Are my medical and claims records confidential?

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

- OPM, this Plan, and our subcontractors when they administer this contract,
- This plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims,
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity, or
- OPM, when reviewing a disputed claim or defending litigation about a claim.
- As part of its administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the name of prescribing physicians, to any treating physicians or dispensing pharmacies.

Section 10. FEHB FACTS *continued*

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old FEHB plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When you lose benefits

What happens if my enrollment in this Plan ends?

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

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

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

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

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

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

Key points about TCC:

- You can pick a new plan.
- If you leave Federal service, you can receive TCC for up to 18 months after you separate.
- If you no longer qualify as a family member, you can receive TCC for up to 36 months.
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

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

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

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

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

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

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

Section 10. FEHB FACTS *continued*

How can I convert to individual coverage?

You may convert to an individual policy if:

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

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice.

However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

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

How can I get a Certificate of Group Health Plan Coverage?

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

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

Department of Defense/FEHB Program Demonstration Project

What is the Department of Defense (DoD) and FEHB Program Demonstration Project?

The National Defense Authorization Act of 1999, Public Law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set-up some special procedures to successfully implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is Eligible?

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

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

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

Where are the demonstration areas?

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

When Can I Join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (self-only) or for you and your family (self and family) during the 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

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

Section 10. FEHB FACTS *continued*

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at **www.tricare.osd.mil/fehbp.** You can also view information about the demonstration project, including "The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project," on the OPM web site at **www.opm.gov.**

Am I eligible for Temporary Continuation of Coverage (TCC)?

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

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

Do I have the 31-Day Extension and Right To Convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

Inspector General Advisory: Stop Health Care Fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/433-NALC and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Index

Summary of Benefits for the NALC Health Benefit Plan - 2000

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 10
	Surgical	**PPO benefit: 85%*** of the surgeon's negotiated rate **Non-PPO benefit: 70%*** of reasonable and customary charges	11 - 12
	Medical	**PPO benefit: 85%***of the doctor's negotiated rate **Non-PPO benefit: 70%*** of the doctor's reasonable and customary charges	15 - 17
	Maternity	Same benefits as for illness or injury	13
	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	14
	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	14
Outpatient care	**Hospital**	**PPO benefit: 85%** of the negotiated rate **Non-PPO benefit: 70%*** of reasonable and customary charges	15 - 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 - 12
	Medical	**PPO benefit:** $15 copay per covered office visit; $5 copay per allergy injection; $5 - $25 copay per routine screening service; other benefits, **85%*** 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	15 - 17
	Maternity	Same benefits as for illness or injury	13
	Home Health Care	No current benefit. See page 17 for Skilled nursing care.	
	Mental Conditions/ Substance Abuse	**PPO benefit:** After satisfaction of a $250 calendar year deductible, **60%** of negotiated rate for 30 visits per year. **Non-PPO benefit:** After satisfaction of a $250 calendar year deductible, **50%** of reasonable and customary charges for 30 visits per year	14
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	17
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 Mail order: You pay a copayment of $12 generic and $25 name brand per prescription or refill	18 -19 18 -19
Dental Care		No current benefit.	
Additional benefits		Childhood immunizations, Pap smears, Skilled nursing care, Skilled nursing facility, Well child care	17
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. **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	27 - 28 27 - 28
	Mental Conditions	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	28

2000 Rate Information for
NALC Health Benefit Plan

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

Postal rates apply to most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee. but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	321	$ 78.83	$46.87	$170.80	$101.55	$ 93.06	$32.64	$ 93.26	$32.44
Self and Family	322	$175.97	$92.66	$381.27	$200.76	$207.74	$60.89	$201.02	$67.61