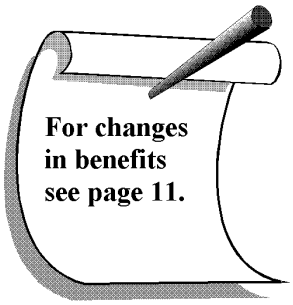
NALC Health Benefit Plan

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

2003

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

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



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

To become a member:

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

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

Enrollment codes for this Plan:

321 Self Only
322 Self and Family

Joint Commission on Accreditation of Healthcare Organizations

URAC ACCREDITED 202.216.9010 ◆ www.urac.org First Health Health Utilization Management

Caremark Therapeutic Services and its 17 pharmacies are JCAHO accredited; United Behavioral Health is JCAHO accredited; and First Health's Clinical Management Services is URAC accredited. See the 2003 Guide for more information on accreditation.

Authorized for distribution by the:

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

FEHB
Federal Employees Health Benefits Program

RI 71-009

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.

- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction

This brochure describes the benefits of the **NALC Health Benefit Plan** under our contract (CS 1067) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for the NALC Health Benefit Plan administrative offices is:

NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 11. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means NALC Health Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW, Washington, DC 20415-3650

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your identification (ID) number over the telephone or to people you do not know, except to your physician, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your physician to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 703/729-4677 or 1-888-636-NALC (6252) and explain the situation.
    - If we do not resolve the issue:

CALL —THE HEALTH CARE FRAUD HOTLINE
202-418-3300

OR WRITE TO:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
    - your child age 22 or older, unless he/she is disabled and incapable of self support.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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

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

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

We also have Preferred Provider Organizations (PPO)

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you receive covered services at reduced cost. First Health is solely responsible for the selection of PPO providers in your area. Contact us for the names of PPO providers, to verify their continued participation, or to request a PPO directory. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure.

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

How we pay providers

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

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

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

Your Rights

OPM requires that all FEHB Plans provide certain information to you. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below:

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

If you want more information about us, call 703/729-4677 or 1-888-636-NALC (6252), or write to NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149. You may also visit our website at www.nalc.org/depart/hbp.

NOTICE OF THE NALC HEALTH BENEFIT PLAN'S PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Understanding Your Health Record/Information

Each time you visit a physician, hospital, or other health care provider, the details of your visit are recorded, and the record becomes part of your individually identifiable health information. This information—your symptoms, examination and test results, diagnosis, and treatment—is protected health information, and we refer to it as "PHI." Health care providers may share PHI as they plan and coordinate treatment, and health plans use PHI to determine benefits and process claims.

II. Our Privacy Practices

Your protected health information allows us to provide prompt and accurate consideration of your health claims. We store PHI through a combination of paper and electronic means and limit its access to individuals trained in the handling of protected health information.

In accordance with the requirements of the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), we safeguard any information you or your health care provider shares with us.

III. Uses and Disclosures of Protected Health Information

Except for the purposes of treatment, payment, and health care operations, or as otherwise described in this notice, we will disclose your PHI only to you or your personal representative (someone who has the legal right or authority to act for you).

We can use and disclose your PHI without individual authorization when our use and disclosure is to carry out treatment, payment, and health care operations.

- Example (treatment): Based upon the PHI in your file, we may contact your physician and discuss possible drug interactions or duplicative therapy.

- Example (payment): We disclose PHI when we ask your physician to clarify information or to provide additional information if your claim form is incomplete.

- Examples (health care operations): We disclose PHI as part of our routine health care operations when we submit individual claims or files for audits. We may use and disclose your protected health information as part of our efforts to uncover instances of provider abuse and fraud. Or, we may combine the protected health information of many participants to help us decide on services for which we should provide coverage.

We also are permitted or required to disclose PHI without your written permission (authorization) for other purposes:

- To Business Associates: We contract with business associates to provide some services. Examples include, but are not limited to, our Preferred Provider Organization and Prescription Drug Program. When these services are contracted, we may disclose your PHI to our business associates so that they can perform the job we've asked them to do in the consideration of your health claim. To protect your protected health information, however, we require our business associates to appropriately safeguard your information.

- To Workers' Compensation Offices: We may disclose your PHI to the extent authorized by, and to the extent necessary to comply with, laws relating to workers' compensation or other similar programs established by law.

- To Public Health Offices: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

- To Health Oversight Agencies: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and legal actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.

- For Health-Related Benefits and Services: We—or our business associates—may contact you or your health care provider to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- For Food and Drug Administration Activities: We may disclose your PHI to a person or organization required by the Food and Drug Administration to track products or to report adverse effects, product defects or problems, or biological product deviations. Your protected health information may be used to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance.

- For Research Studies: We may disclose your PHI to researchers when an institutional review board that has established protocols to ensure the privacy of your protected health information, has approved their research.

- For Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities deemed necessary by military command authorities; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials conducting national security and intelligence activities, including protection of the President.

- For Law Enforcement and Legal Proceedings: We may disclose your PHI in the course of a judicial or administrative proceeding; in response to an order of a court or administrative tribunal; in response to a law enforcement official investigating and/or prosecuting alleged civil or criminal actions; or in response to a subpoena, discovery request, or other lawful process. In most cases, reasonable efforts will be undertaken by the party seeking the protected health information or by the Plan to notify you and give you an opportunity to object to this disclosure.

- Regarding Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the institution or law enforcement official, if the protected health information is necessary for the institution to provide you with health care, to protect the health and safety of you or others, or for the security of the correctional institution.

- For Compliance Verification: We may disclose your PHI to the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the federal regulations regarding privacy.

- For Disaster Relief Purposes: We may disclose your protected health information to any authorized public or private entities assisting in disaster relief efforts.

Whether we use or disclose protected health information for treatment, payment, or health care operations, or for another purpose, we limit our use and disclosure to the minimum necessary information.

We must have your authorization to use or disclose your protected health information for a purpose other than to carry out treatment, payment, or health care operations, or the permitted uses and disclosures set forth above, unless you cannot give an authorization because you are incapacitated or there is an emergency situation.

- Example: We would have to have your written authorization before we could provide your current physician PHI from a prior physician's bills, even if you wanted us to provide the information because the prior physician's records were unavailable.

You may revoke your authorization by writing to us, but your revocation will not apply to actions we took before we received the revocation. Send your request to our Privacy Official, at the address shown in *VIII. How to Contact Us* below. We will not use or disclose protected health information covered by an authorization once we receive your revocation of the authorization.

If a use or disclosure for any purpose is prohibited or materially limited by a federal law other than HIPAA that applies to this Plan, we will meet the standards of the more stringent law.

IV. Specific Uses of Protected Health Information

Our plan is sponsored and administered by the National Association of Letter Carriers (NALC), AFL-CIO. To be eligible for our health benefits, you must be a member of the sponsoring organization. We provide NALC access to our membership files so that they can ensure the membership requirement has been met. We do not disclose claims-related information to the NALC.

V. Your Health Information Rights

Although documents provided to the NALC Health Benefit Plan are our property, the information belongs to you. With respect to protected health information, you have these rights:

- The right to see and get a copy of your protected health information. To request access to inspect and/or obtain a copy of your PHI, you must submit your request in writing to our Privacy Official, indicating the specific information you want. If you request a copy, we will impose a fee to cover the costs of copying and postage. We may decide to deny access to your protected health information. Depending on the circumstances, that decision to deny access may be reviewable by a licensed health professional that was not involved in the initial denial of access.

- The right to request restrictions on certain uses and disclosures of your PHI. To request a restriction, write to our Privacy Official, indicating what information you want to limit; whether you want to limit use, disclosure, or both; and to whom you want the limits to apply. We are not required to agree to a restriction, but if we do, we will abide by our agreement, unless the restricted information is needed for emergency treatment.

- The right to receive confidential communications of your PHI. We will mail our explanation of benefits (EOB) and other payment-related materials to the member at the mailing address we have on file. To request that we send confidential communications by alternate means or to a different location, write to our Privacy Official.

- The right to receive an accounting of disclosures of PHI. You may request an accounting of the disclosures made by the Plan or its business associates including the names of persons and organizations that received your personal health information within six years (or less) of the date on which the accounting is requested, but not prior to April 14, 2003. Submit your request in writing to our Privacy Official.

The listing will not cover disclosures made to carry out treatment, payment or health care operations; disclosures made to you or your personal representative regarding your own PHI; disclosures made to correctional institutions or for law enforcement purposes; or any information that you authorized us to release. The first request within a 12-month period will be free. For additional requests within the 12-month period, we will charge you for the costs of providing the accounting. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time, before any costs are incurred.

- The right to amend the protected health information we have created, if you believe information is wrong or missing, and we agree. If you believe our information about you is incorrect, notify us in writing and we will investigate. Provide us the reason that supports your request. We will correct any errors we find.

We may deny your request for an amendment if it does not include a reason to support your request. Additionally, we may deny your request if you ask us to amend information that 1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; 2) is not part of the health information

kept by us; 3) is not part of the information which you would be permitted to inspect and copy; or 4) is accurate and complete.

If we do not agree to the amendment, you may file a statement of disagreement with us, or you may request that we include your request for amendment along with the information, if and when we disclose your protected health information in the future. We may prepare a written rebuttal to your statement and will provide you with a copy of such rebuttal.

If you have any questions about the right to access, or request correction of, information in your file, contact us.

- The right to obtain a paper copy of our notice of privacy practices (Notice), upon request. Additionally, you may visit our web site at www.nalc.org/depart/hbp to view or download the current notice.

VI. Our responsibilities to you

We at the National Association of Letter Carriers Health Benefit Plan are concerned about protecting the privacy of each of our member's protected health information. We apply the same privacy rules for all members – current and former.

- We are required by law to maintain the privacy of protected health information and to provide notice of our legal duties and privacy practices with respect to protected health information.

- We are required to abide by the terms of our Notice.

- We reserve the right to change the terms of our Notice and to make the new Notice provisions effective for all protected health information we maintain.

- If we make a material revision to the content of this notice, we will provide each current member a new notice by mail, within 60 days of the material revision.

VII. To File a Complaint

If you believe we have violated your privacy rights, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, write to our Privacy Official at the address listed below. There will be no retaliation for your filing a complaint.

VIII. How to Contact Us

If you have questions, you may call our Customer Service Department at 703/729-4677 or 1-888-636-NALC (6252), or you may write to our Privacy Official. If you write to us, please provide a copy of your Member identification card.

The address for our Privacy Official is:

Privacy Official
NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149

IX. Effective date

The terms of this Notice are in effect as of April 14, 2003.

Section 2. How we change for 2003

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5. *Benefits*. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program Wide Changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.
- Three states are added to the list of medically underserved areas: Louisiana, Maine, and West Virginia. Georgia is no longer medically underserved. (Section 3)
- Program information on Medicare is revised. (Sections 4 and 9)
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment. (Section 9)
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage. (Section 11)

Changes to this Plan

- Your share of the NALC Postal premium will increase by 1.8% for Self Only and decrease by 2.3% for Self and Family.
- Your share of the non-Postal premium will increase by 5.6% for Self Only or 4.5% for Self and Family.
- We now offer a PPO network in all states. Previously, we did not offer a PPO network in Maine and offered only a PPO physician network in Maryland.
- A Notice of the NALC Health Benefit Plan's Privacy Practices is included. (Section 1)
- We added a definition of freestanding ambulatory facility in our listing of covered facilities. (Section 3)
- You will have no out-of-pocket costs for services Medicare covers as the primary payer. Previously, you may have had out-of-pocket costs for services that Medicare covered, and we did not. (Section 4)
- We added coverage for fasting lipoprotein profile under Preventive care, adult. (Section 5(a))
- We increased our colorectal cancer screening coverage to include colonoscopy and double contrast barium enema. (Section 5(a))
- We eliminated your copayment for certain preventive care screenings and immunizations for adults when you see a PPO provider. After the deductible has been met, you pay 15% of the Plan allowance. (Section 5(a))
- After the deductible has been met, you pay the applicable coinsurance for a routine pap test. Previously, you paid nothing for the first $35 in charges. (Section 5(a))
- We clarified that limited benefits apply for organ/tissue transplants when other coverage is the primary payer. (Section 5(b))
- We changed the copayment for mail order prescription drugs and supplies. For a 60-day supply, you pay $7 for generic drugs and $20 for name brand; for a 90-day supply, you pay $10 for generic drugs and $30 for name brand. Previously, you paid $8 for generic drugs and $17 for name brand for a 60-day supply, and $12 for generic and $25 for name brand for a 90-day supply. (Section 5(f))
- If you have Medicare, your mail order copayment for a 60-day supply is $5 for generic drugs and $17 for name brand. For a 90-day supply, you pay $7.50 for generic drugs and $25 for name brand. Previously, you paid $5 for generic drugs and $13 for name brand for a 60-day supply, and $7.50 for generic and $19.50 for name brand for a 90-day supply. (Section 5(f))
- We removed the exclusion for coverage of services for illness or injury sustained as a result of an act of war within the United States, its territories, or possessions. (Section 6)
- When you have other coverage and we are the secondary payer, our payment determination period is now per claim. Previously, it was based on a calendar year. (Section 9)

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a provider or fill a prescription at an NALC CareSelect retail pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809; your health benefits enrollment confirmation (for annuitants); or your Employee Express confirmation letter. If you want to obtain a prescription at an NALC CareSelect retail pharmacy and have not received your identification card, contact us at 703/729-4677 or 1-888-636-NALC (6252).

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 703/729-4677 or 1-888-636-NALC (6252), or write to us at 20547 Waverly Court, Ashburn, VA 20149.

Where you get covered care

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

• Covered providers

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

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

Note: When we use the term "physician," it can mean any of the above providers.

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2003, the states are: Alabama, Idaho, Kentucky, Louisiana, Maine, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, West Virginia and Wyoming.

● **Covered facilities**

Covered facilities include:

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

- **Freestanding ambulatory facility:** An outpatient facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or that has Medicare certification.

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

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

  The term "hospital" does not include a convalescent home or extended care facility, or any institution or part thereof which a) is used principally as a convalescent facility, nursing home, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operated as a school or residential treatment facility.

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

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

What you must do to get covered care

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

Transitional care:

Specialty care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or
- lose access to your PPO specialist because we terminate our contract with your specialist for other than cause,

you may be able to continue seeing your specialist and receiving any PPO benefits for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

Hospital care:

We pay for covered services from the effective date of your enrollment. If you are in the hospital, however, when your enrollment in our Plan begins, call our customer service department immediately at 703/729-4677 or 1-888-636-NALC (6252)**.**

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

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

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

How to Get Approval for…

• Your hospital stay

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

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

Warning:

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

How to precertify an admission:

- You, your representative, your physician, or your hospital must call us at 1-800-622-6252 prior to admission, unless your admission is related to a mental health and substance abuse condition. In that case call 1-877-468-1016.

- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- Provide the following information:

  — Enrollee's name and Member identification number;
  — Patient's name, birth date, and phone number;
  — Reason for hospitalization, and proposed treatment or surgery;
  — Name and phone number of admitting physician;
  — Name of hospital or facility; and
  — Number of planned days of confinement.

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

Maternity care

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

If your hospital stay needs to be extended:

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

What happens when you do not follow the precertification rules

- If no one contacted us, we will decide whether the hospital stay was medically necessary.

  — If we determine that the stay was medically necessary, we will pay the inpatient charges, but reduce benefits by $500.
  — If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will pay only for covered medical supplies and services that are otherwise payable on an outpatient basis.

- If we denied the precertification request, we will not pay inpatient hospital benefits. We will pay only for covered medical supplies and services that would be otherwise payable on an outpatient basis.

- When we precertified the admission but you remained in the hospital beyond the number of days we approved, and you do not get the additional days precertified, then:

  — For the part of the admission that was medically necessary, we will pay inpatient benefits, but
  — For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

Exceptions:

You do not need precertification in these cases:

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

Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, you need to precertify with us by calling 1-800-622-6252.

• Other services

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

- Growth hormone therapy (GHT): We cover GHT only when we preauthorize the treatment. Call 1-888-636-NALC (6252) for preauthorization. See Section 5(a). *Treatment therapies.*
- Some drugs, such as those for sexual dysfunction, require prior authorization. Call us at 1-888-636-NALC (6252) for information.
- Organ/tissue transplants and donor expenses: The Plan participates in the **First Health**® National Transplant Program. Before your initial evaluation as a potential candidate for a transplant procedure, you or your physician must contact First Health at 1-800-622-6252 and speak to a Transplant Case Manager. See Section 5(b). *Organ/tissue transplants*.
- Mental health and substance abuse care: United Behavioral Health (UBH) provides the Plan's mental health and substance abuse benefits. Call 1-877-468-1016 for preauthorization. See Section 5(e). *Mental health and substance abuse benefits*.
- Durable medical equipment (DME): Although DME does not require prior authorization, you should call us at 1-888-636-NALC (6252) before you purchase or rent DME so we can give you information on discounted rates. See Section 5(a). *Durable medical equipment*.

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: When you see your PPO physician you pay a $20 copayment per office visit and when you are admitted to a non-PPO hospital, you pay $100 per admission.

- **Deductible**

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

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

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

- **Coinsurance**

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

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

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

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

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

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

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

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

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

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

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

Your catastrophic protection out-of-pocket maximum for coinsurance

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

- $3000 per person or family for services of PPO providers/facilities
- $3500 per person or family for services of PPO and non-PPO providers/facilities, combined

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

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

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

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

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

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

You are responsible for these amounts even after the catastrophic protection out-of-pocket maximum has been met.

Note: If you are not responsible for the balance after our payment for charges incurred at a government facility (such as a facility of the Department of Veterans Affairs), the balance cannot be counted toward out-of-pocket expenses.

When government facilities bill us

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

If we overpay you

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

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

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

If you…

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

Then, for your inpatient hospital care,

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

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

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

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

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

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

When you have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

When you are covered by Medicare Part A and it is primary, you pay no out-of-pocket expenses for services Medicare Part A covers.

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

- If your physician accepts Medicare assignment, then you pay nothing.
- If your physician does not accept Medicare assignment, then you pay nothing because we supplement Medicare's payment up to the limiting charge.

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

Note: When Medicare benefits are exhausted, or services are not covered by Medicare, our benefits are subject to the definitions, limitations and exclusions in this brochure.

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

Section 5. Benefits – OVERVIEW

(See page 11 for how our benefits changed this year and page 76 for a benefits summary.)

NOTE: This Benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 703/729-4677 or 1-888-636-NALC (6252).

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • Office or outpatient visits	PPO: $20 copayment per visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Professional services of physicians • Hospital care • Skilled nursing facility care • Initial examination of a newborn child covered under a family enrollment • Medical consultations • Second surgical opinions • Home visits Note: For routine post-operative surgical care, see Section 5(b). *Surgical procedures*.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Diagnostic and treatment services – Continued on next page

Diagnostic and treatment services *(continued)*	**You pay**
Not covered: • *Routine physical checkups and related tests* • *Routine eye and hearing examinations* • *Services by chiropractors, except in those states designated as medically underserved areas* • *Nonsurgical treatment for weight reduction or obesity*	*All charges*
Lab, X-ray and other diagnostic tests	
Tests and their interpretation, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT scans/MRI • Ultrasound • Electrocardiogram (EKG) • Electroencephalogram (EEG)	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount Note: When tests are performed during an inpatient confinement, no deductible applies.
Not covered: Routine tests, except listed under Preventive care, adult *in this section.*	*All charges*
Preventive care, adult	
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster—one every 10 years, age 19 and older (except as provided for under *Preventive care, children* in this section) • Influenza vaccine—one annually, age 65 and older • Pneumococcal vaccine, age 65 and older Routine screenings, limited to: • Pap test Note: We cover the office visit if it is on the same day as the pap test. See *Diagnostic and treatment services* in this section. • Chlamydial infection test • Total blood cholesterol—one every three years • Fasting Lipoprotein Profile (total cholesterol, LDL, HDL, and triglycerides) —one every 5 years, age 20 and older • Prostate Specific Antigen (PSA) test —one annually for men age 40 and older • Mammogram—for women age 35 and older, as follows: — Ages 35 through 39, one during this five year period — Ages 40 through 64, one every calendar year — Ages 65 and older, one every two consecutive calendar years • Colorectal cancer screening, including: — Fecal occult blood test—one annually, age 40 and older — Double Contrast Barium Enema (DCBE) —one every five years, age 50 and older	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, adult – Continued on next page

Preventive care, adult *(continued)*	**You pay**
— Sigmoidoscopy screening—one every five years, age 50 and older — Colonoscopy screening—one every 10 years, age 50 and older	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between the Plan allowance and the billed amount
Not covered: Routine office visit associated with preventive care, except as noted above	
Preventive care, children	
Childhood immunizations, ages 3 through 21, limited to: • Immunizations recommended by the American Academy of Pediatrics • Meningococcal immunization—lifetime limit of two vaccinations	PPO: Nothing (No deductible) Non-PPO: The difference, if any, between our allowance and the billed amount (No deductible)
• Well-child care—routine examinations and immunizations, through age 2 Note: For the coverage of the initial newborn exam see *Diagnostic and treatment services* in this section.	PPO: Nothing (No deductible) Non-PPO: The difference, if any, between our allowance and the billed amount (No deductible)
• Examinations, limited to: — Examinations for amblyopia (lazy eye) and strabismus (crossed eyes)—limited to one screening examination, ages 2 through 6 — Examinations done on the day of immunizations, ages 3 through 21	PPO: $20 copayment per visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Amniocentesis	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Maternity care – Continued on next page

Maternity care *(continued)*	**You pay**
• Group B streptococcus infection screening • Sonograms • Fetal monitoring • Other tests medically indicated for the unborn child Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see Section 3. *How to get approval for…* for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you, your representative, your physician, or your hospital must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • The circumcision charge for an infant covered under a Self and Family enrollment is payable under surgical benefits. See Section 5(b). *Surgical procedures*. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c). *Inpatient hospital* and Section 5(b). *Surgical procedures.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Routine sonograms to determine fetal age, size, or sex	*All charges*
Family planning	
Voluntary family planning services, limited to: • Voluntary sterilization (see Section 5(b). *Surgical procedures*) • Implanted contraceptives • Intrauterine devices (IUDs)	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Injectable contraceptive drugs (such as Depo provera) • Diaphragms Note: We cover oral contraceptives only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits*.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Reversal of voluntary surgical sterilization, genetic counseling	*All charges*
Infertility services	
Diagnosis and treatment of infertility, except as shown in *Not covered*. Note: For surgical services see Section 5(b). *Surgical procedures*. Note: Prescription drugs for infertility are covered only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Infertility services – Continued on next page

Infertility services *(continued)*	**You pay**
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* — *Artificial insemination* — *In vitro fertilization* — *Embryo transfer and gamete intrafallopian tube transfer (GIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	
• Testing • Treatment, except for allergy injections • Allergy serum	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Allergy injections	PPO: $5 copayment each (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Provocative food testing and sublingual allergy desensitization* • *Environmental control units, such as air conditioners, purifiers, humidifiers, and dehumidifiers*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b). *Organ/tissue transplants*. • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Respiratory and inhalation therapies • Growth hormone therapy (GHT) Note: We cover GHT only when it is preauthorized through our disease management program. Call 703/729-4677 or 1-888-636-NALC (6252) for preauthorization. If you do not preauthorize, we will not cover GHT or related services and supplies. Note: The growth hormone is covered under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits*.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Chelation therapy, except as treatment for acute arsenic, gold, lead, or mercury poisoning	*All charges*

Physical and occupational therapies	You pay
• A combined total of 50 visits per calendar year for treatment provided by a licensed registered therapist or physician for the following: — Physical therapy — Occupational therapy Therapy is covered when the attending physician: • Orders the care; • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed. Note: We cover physical and occupational therapy only to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Maintenance therapy, including cardiac rehabilitation and exercise programs	*All charges*
Speech therapy	
• Up to 30 visits per calendar year for treatment provided by a licensed registered speech therapist or physician Therapy is covered when the attending physician: • Orders the care; • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Maintenance therapy	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing testing for covered diagnoses, such as otitis media and mastoiditis • First hearing aid and examination, limited to services necessitated by accidental injury	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Routine hearing testing* • *Hearing aid and examination, except when necessitated by accidental injury*	*All charges*
Vision services (testing, treatment, and supplies)	
• Eye examinations for covered diagnoses, such as cataract and glaucoma	PPO: $20 copayment per visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Vision services – Continued on next page

Vision services (testing, treatment, and supplies) *(continued)*	**You pay**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: For examinations for amblyopia and strabismus, see *Preventive care, children* in this section.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Refractions*	*All charges*
Foot care	
Nonsurgical routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Surgical procedures for routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes • Open cutting, such as the removal of bunions or bone spurs	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotics, arch supports, heel pads and cups* • *Orthopedic and corrective shoes*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Custom-made durable braces for legs, arms, neck, and back • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy Note: Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy are paid as hospital benefits. See Section 5(c). *Inpatient hospital.* Insertion of the device is paid as surgery. See Section 5(b). *Surgical procedures.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Orthopedic and prosthetic devices – Continued on next page

Orthopedic and prosthetic devices *(continued)*	**You pay**
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics (shoe inserts)* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacement provided less than 3 years after the last one we covered*	*All charges*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 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.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Note: Call us at 703/729-4677 or 1-888-636-NALC (6252) as soon as your physician prescribes equipment or supplies. We have arranged with a health care provider to rent or sell durable medical equipment at discounted rates and will tell you more about this service when you call. We cover rental or purchase (at our option) including repair and adjustment of durable medical equipment, such as: • Oxygen and oxygen apparatus • Dialysis appliances • Hospital beds • Wheelchairs • Crutches, canes, and walkers We also cover supplies, such as: • Insulin and diabetic supplies • Needles and syringes for covered injectables • Ostomy and catheter supplies • Home IV and antibiotic therapy supplies	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Durable medical equipment (DME) – Continued on next page

Durable medical equipment (DME) *(continued)*	**You pay**
Not covered: • *DME replacements provided less than 3 years after the last one we covered* • *Sun or heat lamps, whirlpool baths, saunas and similar household equipment* • *Safety, convenience, and exercise equipment* • *Communication equipment including computer "story boards" or "light talkers"* • *Enhanced vision systems, computer switch boards or environmental control units* • *Heating pads, air conditioners, purifiers, and humidifiers* • *Stair climbing equipment, stair glides, ramps, and elevators* • *Modifications or alterations to vehicles or households* • *Other items (such as wigs) that do not meet the criteria 1 thru 6 above*	*All charges*
Home health services	
Up to 90 days per calendar year (with a maximum Plan payment of $75 per day) when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.) provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed.	PPO: 20% of the Plan allowance (No deductible) and all charges after we pay $75 per day Non-PPO: 20% of the Plan allowance (No deductible) and all charges after we pay $75 per day
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	
Coverage limited to medically underserved areas. See Section 3. *Covered providers.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Alternative treatments	
• Acupuncture, limited to treatment by a doctor of medicine or osteopathy for pain relief	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Alternative treatments – Continued on next page

Alternative treatments (*continued)*	**You pay**
Not covered: Naturopathic services Note: In medically underserved areas, we may cover services of alternative treatment providers. See Section 3. *Covered providers.*	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation—One smoking cessation program per member per lifetime, up to a maximum Plan payment of $100 including all related expenses such as drugs Note: You must meet $250 per person ($500 per family) of your calendar year deductible before this benefit is payable.	PPO: Nothing for the first $100 (No deductible) Non-PPO: Nothing for the first $100 (No deductible)
• Diabetes training for self-management when: — Prescribed by the attending physician, and — Administered by a covered provider, such as a registered nurse.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Surgical procedures - Continued on next page

Surgical procedures *(continued)*	**You pay**
• Removal of tumors and cysts • Correction of congenital anomalies • Gastric bypass or stapling for treatment of morbid obesity—a condition in which an individual weighs 100 pounds or 100% over his or her normal weight with complicating medical conditions and attempts to reduce weight using a doctor-monitored diet and exercise program were unsuccessful; patients must be age 18 or older • Insertion of internal prosthetic devices. See Section 5(a). *Orthopedic and prosthetic devices,* for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Surgically implanted contraceptives, and intrauterine devices (IUDs) • Debridement of burns Note: When multiple or bilateral surgical procedures add complexity to an operative session, the Plan allowance for the second or less expensive procedure is one-half of what the Plan allowance would have been if that procedure had been performed independently. The Plan allowance for an assistant surgeon will not exceed 25% of our allowance for the surgeon.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our payment and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone)* • *Cosmetic surgery, except for: repair of accidental injury if repair is initiated within six months after an accident; correction of a congenital anomaly; or breast reconstruction following a mastectomy* • *Radial keratotomy and other refractive surgery* • *Procedures performed through the same incision deemed incidental to the total surgery, such as appendectomy, lysis of adhesion, puncture of ovarian cyst* • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standby surgeons are medically necessary* • *Cutting, trimming, or removal of corns, calluses, or the free edge of toenails; and similar routine treatment of conditions of the foot, except as listed under Section 5(a)*. Foot care	*All charges*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: — The condition produced a major effect on the member's appearance; and — The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a congenital anomaly (condition that existed at or from birth and is a significant deviation from the common form or norm). Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: — Surgery to produce a symmetrical appearance on the other breast — Treatment of any physical complications, such as lymphedemas Note: Congenital anomaly does not include conditions related to teeth or intra-oral structures supporting the teeth. Note: We cover internal and external breast prostheses, surgical bras and replacements. See Section 5(a). *Orthopedic and prosthetic devices*, and Section 5(c). *Inpatient hospital*. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated within six months* • *Injections of silicone, collagens and similar substances* • *Surgeries related to sex transformation or sexual dysfunction*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Treatment of fractures of the jaw or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Oral and maxillofacial surgery – Continued on next page

Oral and maxillofacial surgery *(continued)*	**You pay**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
Limited to: • Bone • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver • Lung: Single—only for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, or emphysema; Double—only for patients with cystic fibrosis • Pancreas • Allogenic bone marrow transplants, limited to patients with acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, aplastic anemia, chronic myelogenous leukemia, infantile malignant osteoporosis, severe combined immunodeficiency, thalassemia major, or Wiskott-Aldrich syndrome • Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for acute lymphocytic or non-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 • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas	Nothing, for services obtained through the National Transplant Program. (No deductible) PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
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 physician must contact First Health at 1-800-622-6252 and speak to a Transplant Case Manager. You will be given information about this program including a list of participating providers. Charges for services performed by a National Transplant Program provider, whether incurred by the recipient or donor are paid at 100%. Participants in the program must obtain prior approval from the Plan to receive limited travel and lodging benefits.	Nothing, for services obtained through the National Transplant Program (No deductible)

Organ/tissue transplants – Continued on next page

Organ/tissue transplants *(continued)*	**You pay**
Limited Benefits—If you do not obtain prior approval or do not use a designated facility, or if we are not the primary payer, we pay a maximum of $100,000 for each listed transplant (kidney limit, $50,000), for these combined expenses: pre-transplant evaluation; organ procurement; and inpatient hospital, surgical and medical expenses. We pay benefits according to the appropriate benefit section, such as Section 5(c). *Inpatient hospital,* and *Surgical procedures*. The limitation applies to expenses incurred by either the recipient or donor. Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute (NCI)- or National Institute of Health (NIH)-approved clinical trial at a designated center for excellence when approved by our medical director in accordance with the Plan's protocols. Note: Some transplants listed may not be covered through the National Transplant Program. Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Travel and lodging expenses, except when approved by the Plan* • *Implants of artificial organs* • *Transplants and related services and supplies not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient)	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (No deductible) Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for the anesthesia charges.
Professional services provided in: • Hospital outpatient department • Ambulatory surgical center • Office • Other outpatient facility	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for the anesthesia charges.

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
NOTE: The calendar year deductible applies ONLY when we say "(calendar year deductible applies)".	
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: We cover a private room only when you must be isolated to prevent contagion. Otherwise, we pay the hospital's average charge for semiprivate accommodations. If the hospital has private rooms only, we base our payment on the average semiprivate rate of the most comparable hospital in the area. Note: When the non-PPO hospital bills a flat rate, we prorate the charge as follows: 30% room and board and 70% other charges.	PPO: 10% of the Plan allowance Non-PPO: $100 copayment per admission and 30% of the Plan allowance

Inpatient hospital - Continued on next page

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Preadmission testing (within 7 days of admission), limited to: — Chest X-rays — Electrocardiograms — Urinalysis — Blood work • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Internal prostheses • Professional ambulance service to the nearest hospital equipped to handle your condition • Occupational, physical, and speech therapy Note: We base payment on who bills for the services or supplies. For example, when the hospital bills for its nurse anesthetist's services, we pay hospital benefits (*Inpatient hospital)* and when the anesthesiologist bills, we pay anesthesia benefits**.** See Section 5(b). *Surgical procedures*. Note: We cover your admission for dental procedures only when you have a nondental physical impairment that makes admission necessary to safeguard your health. We do not cover the dental procedures. Note: We cover your admission for inpatient foot treatment even if no other benefits are payable. Note: Diagnostic tests, such as magnetic resonance imaging, throat cultures, or similar studies are not considered as preadmission testing.	PPO: 10% of the Plan allowance Non-PPO: $100 copayment per admission and 30% of the Plan allowance
Take-home items • Medical supplies, appliances, and equipment; and any covered items billed by a hospital for use at home	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance (calendar year deductible applies)

Inpatient hospital – Continued on next page

Inpatient hospital *(continued)*	**You pay**
Not covered: • *Any part of a hospital admission that is not medically necessary (See Section 10.* Definitions . . . Medical Necessity*), such as subacute care, long term care, long term acute care, intermediate care, or when you do not need acute hospital inpatient care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting.* • *Custodial care; see Section 10.* Definitions . . . Custodial care • *Non-covered facilities, such as nursing homes, extended care facilities and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
Services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental physical impairment. We do not cover the dental procedures.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Plan pays for pre-operative testing within 7 days of surgery. Screening tests, limited to: • Chest X-rays • Electrocardiograms • Urinalysis • Blood work Note: Diagnostic tests, such as magnetic resonance imaging, throat cultures, or similar studies are not considered as preadmission testing.	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance (No deductible), and the difference, if any, between our allowance and the billed amount
Not covered: Personal comfort items	*All charges*

Skilled nursing care facility benefits	
Limited to care in a skilled nursing facility (SNF) when your Medicare Part A is primary, and: • Medicare has made payment, we cover the applicable copayments; or • Medicare's benefits are exhausted, we cover semiprivate room, board, services, and supplies in a SNF during the initial 30 days per confinement provided: **1.** You are admitted directly from a hospital stay of at least 3 consecutive days; **2.** You are admitted for the same condition as the hospital stay; and **3.** Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.	PPO: Nothing Non-PPO: Nothing
Not covered: Custodial care	*All charges*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. Limited benefits: We pay up to $3000 per lifetime for a combination of inpatient and outpatient services.	PPO: 15% of the Plan allowance, and all charges after we pay $3000 (calendar year deductible applies) Non-PPO: 30% of the Plan allowance, and all charges after we pay $3000 (calendar year deductible applies)
Not covered: • *Private nursing care* • *Homemaker services* • *Bereavement services*	*All charges*
Ambulance	
Local professional ambulance service when medically necessary	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Not covered: Transportation (other than professional ambulance services), such as by ambulette or medicab	*All charges*

Section 5(d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is an accidental injury?

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

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

Accidental injury - Continued on next page

Accidental injury *(continued)*	**You pay**
If you receive care for your accidental injury after 72 hours, we cover outpatient hospital and physician services and supplies not related to surgical procedures.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between the Plan allowance and the billed amount
Medical emergency	
Outpatient medical services and supplies. See Section 5(a). *Medical services and supplies . . .*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Surgical services. See Section 5(b). *Surgical procedures.*	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Ambulance	
Local professional ambulance service when medically necessary, not related to an accidental injury	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Transportation (other than professional ambulance services), such as by ambulette or medicab	*All charges*

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

In-Network Benefits

IMPORTANT

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is a separate calendar year deductible for In-Network mental health and substance abuse of $250 per person ($500 per family). This calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" to show when the calendar year deductible does not apply.
- When no In-Network provider is available, Out-of-Network benefits will be paid.
- Be sure to read Section 4. *Your costs for covered services,* for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9**.** *Coordinating benefits with other coverage.*
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below; then Out-of-Network benefits begin on page 46.

IMPORTANT

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

In-Network benefits - Continued on next page

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

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must obtain a treatment plan and follow all of the following network authorization processes:

United Behavioral Health provides our mental health and substance abuse benefits. Call 1-877-468-1016 to locate network clinicians who can best meet your needs, and to receive authorization to see a provider. You and your provider will receive written confirmation of the authorization from United Behavioral Health for the initial and any ongoing authorizations.

- **Exceptions**

When Medicare is the primary payer, call the Plan at 703/729-4677 or 1-888-636-NALC (6252) to preauthorize treatment if:

- Medicare does not cover your services; or
- Medicare hospital benefits are exhausted and you do not want to use your Medicare lifetime reserve days.

Note: You do not need to preauthorize treatment when Medicare covers your services.

Where to file claims

If you are using In-Network benefits for mental health and substance abuse treatment, you will not have to submit a claim. United Behavioral Health's network providers are responsible for filing. Claims should be submitted to:

United Behavioral Health
P.O. Box 744925
Houston, TX 77274-4925
Questions? 1-877-468-1016

Out-of-Network Benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible for inpatient and outpatient professional services is $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible in a treatment facility is $300 per person.
- Be sure to read Section 4. *Your costs for covered services,* for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage*.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Out-of-Network benefits	
Inpatient and outpatient professional services of providers, such as psychiatrists, psychologists, clinical social workers, or community mental health organizations: • Up to 30 visits per calendar year for diagnostic tests; office, outpatient, and hospital visits	$300 mental conditions/substance abuse calendar year deductible, then 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount; all charges after 30 visits
Up to 50 days per calendar year for inpatient hospital charges: • Ward or semiprivate accommodations • Other charges	$500 copayment per admission plus 50% of the Plan allowance (No deductible); all charges after 50 days
Up to a 30-day lifetime maximum for inpatient care in a treatment facility for rehabilitative substance abuse: • Ward or semiprivate accommodations • Other charges	$300 treatment facility calendar year deductible, then 50% of the Plan allowance; all charges after 30 days

Out-of-Network benefits - Continued on next page

Out-of-Network benefits *(continued)*	**You pay**
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 half-way houses, and members of their staffs* Note: In medically underserved areas, we may cover services of pastoral counselors. See Section 3. *Covered providers.*	*All charges*

Lifetime maximum	Out-of-Network inpatient care for the treatment of substance abuse in a treatment facility is limited to a 30-day lifetime benefit.
Precertification	The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive these Out-of-Network benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See Section 3 for details.
Where to file claims	United Behavioral Health P.O. Box 744925 Houston, TX 77274-4925 Questions? 1-877-468-1016

Section 5(f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed medications and supplies as described in the chart beginning on page 50.
- All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year drug deductible of $25 per person or $50 per family applies only to non-network benefits. We say "(No deductible)" to show when the calendar year drug deductible does not apply.
- Some drugs require prior authorization. Call the Plan at 703/729-4677 or 1-888-636-NALC (6252) for information.
- Maximum dosage dispensed may be limited by protocols established by the Plan.
- When we say "Medicare" in this Section we mean you have Medicare Part B and it is primary.
- Be sure to read Section 4.*Your costs for covered services,* for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage*.

IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician or a licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you purchase your generic drug at a network pharmacy or through our mail order program.
- **Network pharmacy—**Present your Plan identification card at an NALC CareSelect Network pharmacy to purchase prescription drugs. Call 1-800-933-NALC (6252) to locate the nearest network pharmacy.
- **Non-network pharmacy**—You may purchase prescriptions at pharmacies that are not part of our network. You pay full cost and must file a claim for reimbursement. See *When you have to file a claim* in this Section.
- **Mail order—**Complete the patient profile/order form. Send this form, along with your prescription(s) and payment, in the preaddressed envelope to:

  NALC Prescription Drug Program
  P.O. Box 7615
  Mount Prospect, IL 60056-7615

- **We use an open formulary.** If your physician believes a name brand drug is necessary, or there is no generic available, your physician may prescribe a name brand drug from our formulary list. These formulary name brand drugs are selected to meet patient needs at lower cost. To order the formulary pamphlet, call 1-800-933-NALC (6252).
- **These are the dispensing limitations.**
  - — Network retail pharmacy—You may obtain up to a 30-day supply plus one refill for each prescription. No deductible applies. You may continue to purchase refills at the Network pharmacy, however benefits will be payable at the non-network retail pharmacy benefit level**.**
  - — Non-network retail pharmacy—You may obtain up to a 30-day supply and unlimited refills for each prescription. You will need to file a claim for reimbursement.
  - — Mail order—You may order up to a 60-day or 90-day (21-day minimum) supply of medication for each prescription or refill. No deductible applies. You cannot obtain a refill until 75% of the drug has been used. Medications dispensed through the mail order program are subject to the following standards: the professional judgment of the pharmacist, limitations imposed on controlled substances, manufacturer's recommendations, and applicable state law.

- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- Why use generic drugs? Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you—and us—less than a name brand prescription.

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

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

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

Note: If you have questions about the Program, wish to locate an NALC CareSelect Network retail pharmacy, or need additional claim forms, call 1-800-933-NALC (6252) (7:00 a.m. – 9:00 p.m., Monday through Friday; 8:00 a.m. – 12 noon, Saturday, Central time).

Benefit Description begins on next page

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year drug deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	
You may purchase the following medications and supplies from a pharmacy or by mail: • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, except as shown in *Not covered* • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Drugs for sexual dysfunction (only when the dysfunction is caused by medically documented organic disease and prior authorization has been given)	Retail: • Network retail: 25% of cost (No deductible) • Network retail Medicare: 15% of cost (No deductible) • Non-network retail: 40% of the Plan allowance, and the difference, if any, between our allowance and the billed amount • Non-network retail Medicare: 40% of the Plan allowance, and the difference, if any, between our allowance and the billed amount (No deductible) Mail order: • 60-day supply: $7 generic/$20 name brand (No deductible) • 90-day supply: $10 generic/$30 name brand (No deductible) Mail order Medicare: • 60-day supply: $5 generic/$17 name brand (No deductible) • 90-day supply: $7.50 generic/$25 name brand (No deductible) Note: If there is no generic equivalent available, you will have to pay the name brand copay.
Not covered: • *Drugs and supplies when prescribed for cosmetic purposes* • *Vitamins, nutrients and food supplements, even when a physician prescribes or administers them* • *Over-the-counter medicines and supplies* • Drugs for smoking cessation, except as described in Section 5(a). *Educational Classes and Programs*.	*All charges*

Section 5(g). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24-hour nurse line	You may call a registered nurse at 1-800-622-NALC (6252) 24 hours a day, 7 days a week, to discuss your health concerns and treatment options.
24-hour help line for mental health and substance abuse	You may call 1-877-468-1016, 24 hours a day, 7 days a week, to access in-person support for a wide range of concerns, including depression, eating disorders, coping with grief and loss, alcohol or drug dependency, physical abuse and managing stress.
Services for deaf and hearing impaired	TTY lines are available for the following: CAREMARK: 1-800-238-1217 (prescription benefit information) First Health: 1-800-259-8179 (PPO locator, 24-hour nurse line, medical inpatient hospital precertification, National Transplant Program) United Behavioral Health: 1-800-842-2479 (mental health and substance abuse information)
Disease management programs	These programs offer a considerable amount of personalized attention from clinicians and program educators. Nurse educators are available to discuss lifestyle changes, therapeutic outcomes, and other health related matters to assist patients in dealing with their experiences. Support is available for patients with multiple sclerosis, growth hormone deficiency, hemophilia, hepatitis, diabetes, and other diseases. You may be contacted about one of these programs.
Worldwide coverage	We cover the medical care you receive outside the United States, subject to the terms and conditions of this brochure. See Section 7. *Overseas claims*.

Section 5(h). Dental benefits

We have no dental benefit.

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

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

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

Hospital Plus (hospital indemnity)

Hospital Plus is a hospital indemnity policy available for purchase from the United States 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 a $75 a day, $50 a day, or $30 a day plan. Members can insure their spouses and eligible children also. The spousal coverage is the same as the member's. Children's coverages are limited to either $45 a day, $30 a day, or $18 a day plans. Benefits will be based on the number of days in the hospital, up to 365 days or as much as $27,375 (if a $75 a day benefit is chosen).

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

This plan is available to all qualified members regardless of their age. Hospital Plus is renewable for life and 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, 8:00 a.m. – 3:30 p.m. or 1-800-424-5184 Tuesdays and Thursdays, 8:00 a.m. - 3:30 p.m., Eastern time.

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

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms, claims filing advice, or answers about our benefits, contact us at 703/729-4677 or 1-888-636-NALC (6252) or at our website at www.nalc.org/depart/hbp.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 703/729-4677 or 1-888-636-NALC (6252).

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

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

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

In addition:

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

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as

evidence of your claim. We will not provide duplicate or year-end statements**,** except as required by the HIPAA Privacy Rule. See Section 1. *Facts about this fee-for-service plan***.**

Deadline for filing your claim

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

Overseas claims

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

When we need more information

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

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

Section 8. The disputed claims process

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

Step	Description

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

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

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

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

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

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

We will write to you with our decision.

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

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

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

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

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

a) We haven't responded to your initial request for care or preauthorization/prior approval, then call us at 703/729-4677 or 1-888-636-NALC (6252) and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they too can expedite your request, or
- You may call OPM's Health Benefits Contracts Division 2 at 202/606-3818 between 8:00 a.m. and 5:00 p.m. Eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

The Plan limits some benefits, such as physical therapy and home health visits. If the primary plan pays, we may pay over these limits as long as our payment on the claim does not exceed our Plan allowance.

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

- **The Original Medicare Plan (Part A or Part B)**

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

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

Claims process when you have the Original Medicare Plan — You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits. You will not need to do anything. If you have questions, call us at 703/729-4677 or 1-888-636-NALC (6252).

We waive some costs if the Original Medicare Plan is your primary payer — We will waive some out-of-pocket costs as follows:

- If you have Medicare Part A as primary payer, we waive:
  - The copayment for a hospital admission
  - The coinsurance for a hospital admission
  - The deductible for inpatient care in a treatment facility

- If you have Medicare Part B as primary payer, we waive:
  - The PPO copayments for office or outpatient visits
  - The PPO copayments for allergy injections
  - The coinsurance for services billed by physicians, other health care professionals, and facilities
  - All calendar year deductibles

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

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

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

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare managed care plan, the following options are available to you:

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

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

- **Private contract with your physician**

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

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it**.**

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to

re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

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

If OWCP or a similar agency disallows benefits for your treatment, we will pay the benefits described in this brochure.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Admission

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

Assignment

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

Calendar year

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

Coinsurance

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

Congenital anomaly

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

Copayment

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

Cosmetic surgery

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

Covered services

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

Custodial care

Treatment or services that help the patient with daily living activities, or can safely and reasonably be provided by a person that is not medically skilled, regardless of who recommends them or where they are provided. Custodial care, sometimes called "long term care," includes such services as:

- Caring for personal needs, such as helping the patient bathe, dress, or eat;
- Homemaking, such as preparing meals or planning special diets;
- Moving the patient, or helping the patient walk, get in and out of bed, or exercise;
- Acting as a companion or sitter;
- Supervising self-administered medication; or
- Performing services that require minimal instruction, such as recording temperature, pulse, and respirations; or administration and monitoring of feeding systems.

The Plan determines whether services are custodial care.

Deductible

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

Effective date

The effective date of benefits described in this brochure is:

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

Experimental or investigational services

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

A medical treatment or procedure, or a drug, device, or biological product is considered experimental or investigational if 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, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis; or
- The consensus of opinion among experts is that further studies or clinical trials are necessary to determine its toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis.

Our Medical Director reviews current medical resources to determine whether a service or supply is experimental or investigational. We will seek an independent expert opinion if necessary.

Group health coverage

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

Medical necessity

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

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

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

Mental health and substance abuse

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

Plan allowance

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

PPO benefits:
For services rendered by a covered provider that participates in the Plan's PPO network, our allowance is based on a negotiated rate agreed to under the providers' network agreement. These providers accept the Plan allowance as their charge.

In-Network mental health and substance abuse benefits:
For services rendered by a covered provider that participates in the Plan's mental health and substance abuse network, our allowance is based on a negotiated rate agreed to under the providers' network agreement. These providers accept the Plan allowance as their charge.

Non-PPO benefits:
When you do not use a PPO provider, we may use one of the following methods:

- In geographic areas where you have adequate access to a PPO provider, but do not use one, our allowance is based on the average PPO negotiated rate for that region;
- If you do not have adequate access to a PPO provider, our allowance is based on the 80th percentile of data gathered by Ingenix, Inc., including both the Prevailing Healthcare Charges System for surgeries and Medical Data Research for physician and other professional services; or
- For medication charges, our allowance is based on the average wholesale price from data prepared by Drug Topics: Red Book.

Out-of-Network mental health and substance abuse benefits:
Our allowance is based on the 80th percentile of data gathered by Ingenix, Inc., for physician and other professional services when you:

- Do not preauthorize your treatment;
- Do not follow the authorized treatment plan; or
- Do not use an In-Network provider.

Note: For other categories of benefits and for certain specific services within each of the above categories, exceptions to the usual method of determining the Plan allowance may exist. At times, we may seek an independent expert opinion to determine our Plan allowance.

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

Preadmission testing

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

Us/We

Us and we refer to the NALC Health Benefit Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

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

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

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

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

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB)

Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB

coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

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; or
- 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 that qualifies them for coverage, or receiving the information, whichever is later.

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

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protection for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC)* under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health): refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But…

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling 1-800-LTC-FEDS (1-800-582-3337) (TDD for the hearing impaired: 1-800-843-3557) or visiting www.ltcfeds.com to get more information and to request an application.

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Do not rely on this page; it is for your convenience and may not show all pages where the term appears.

Notes

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Notes

Summary of benefits for the NALC Health Benefit Plan – 2003

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: $20 copayment per office visit; $5 copayment per allergy injection; routine screening services and other nonsurgical services, 15%* of our allowance Non-PPO: 30%* of our allowance	23
Services provided by a hospital: • Inpatient ..... • Outpatient	PPO: 10% of our allowance Non-PPO: $100 copayment per admission, 30% of our allowance PPO: 15%* of our allowance Non-PPO: 30%* of our allowance	38 40
Emergency benefits: • Accidental injury ..... • Medical emergency	Within 72 hours: Nothing for nonsurgical outpatient care After 72 hours: PPO: 15%* of our allowance Non-PPO: 30%* of our allowance Regular cost sharing	42 43
Mental health and substance abuse treatment.....	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	44 46
Prescription drugs	Network retail: 25% of cost Network retail Medicare: 15% of cost Non-network retail: $25 deductible, 40% of our allowance Non-network retail Medicare: 40% of our allowance Mail order: 60-day supply, $7 generic/$20 name brand Mail order: 90-day supply, $10 generic/$30 name brand Mail order Medicare: 60-day supply, $5 generic/$17 name brand Mail order Medicare: 90-day supply, $7.50 generic/$25 name brand	50
Dental Care	All charges	52
Special features: • Flexible benefits option • 24-hour nurse line • 24-hour help line for mental health and substance abuse • Services for deaf and hearing impaired • Disease management programs • Worldwide coverage		51
Protection against catastrophic costs (your out-of-pocket maximum)	Services with coinsurance (excluding mental health and substance abuse care), nothing after your coinsurance expenses total: • $3000 for PPO providers/facilities • $3500 for Non-PPO providers/facilities. When you use a combination of PPO and Non-PPO providers your out-of-pocket expense will not exceed $3500. Mental health and substance abuse benefits, nothing after your coinsurance expenses total: • $3000 for In-Network mental health and substance abuse providers/facilities • $8000 for Out-of-Network mental health and substance abuse inpatient hospital treatment (after 50 days you pay all charges) Some costs do not count toward this protection.	18

2003 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 career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	**321**	**$109.30**	**$48.44**	**$236.82**	**$104.95**	**$129.03**	**$28.71**
High Option Self and Family	**322**	**$249.62**	**$87.45**	**$540.84**	**$189.48**	**$294.70**	**$42.37**