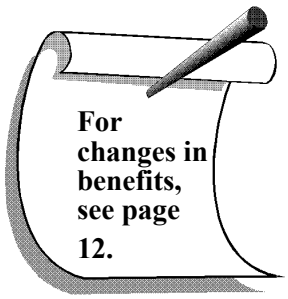
NALC Health Benefit Plan

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

2009

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:

- A federal or postal employee or annuitant eligible to enroll in the Federal Employees Health Benefits Program;
- A former spouse eligible for coverage under the Spouse Equity Law; or
- An employee, former spouse, or child eligible for Temporary Continuation of Coverage (TCC).

To enroll, you must be or become a member of the National Association of Letter Carriers.

To become a member:

- If you are a Postal Service employee, you must be a dues-paying member of an NALC local branch.
- If you are a non-postal employee, annuitant, survivor annuitant, or a Spouse Equity or TCC enrollee, you become an associate member of NALC when you enroll in the NALC Health Benefit Plan. See page 65 for more details.

Membership dues: NALC dues vary by local branch. Associate members will be billed by the NALC for the $36 annual membership fee, except where exempt by law.

Enrollment codes for this Plan:

321 Self Only
322 Self and Family

JCAHO accreditation: CVS/Caremark's 17 Specialty pharmacies and OptumHealth Behavioral Solutions
URAC accreditation: CVS/Caremark's AccordantCare™ Case Management, Caremark Consumer Health Interactive Web site, CVS/Caremark Pharmacy Benefit Management, CVS/Caremark Drug Therapy Management; CIGNA HealthCare Case Management and Health Utilization Management, and Health Call Center; and OptumHealth Behavioral Solutions
NCQA accreditation: CVS/Caremark's 22 AccordantCare™ Health Management Programs and CIGNA HealthCare PPO Network

See the 2009 Guide for more information on accreditation.

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

RI 71-009

Important Notice from NALC Health Benefit Plan About

Our Prescription Drug Coverage and Medicare

OPM has determined that the NALC Health Benefit Plan prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

Visit www.medicare.gov for personalized help.

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of the NALC Health Benefit Plan under our contract (CS 1067) with the United States 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, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 12. 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 United States 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 U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 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 Program (FEHB) 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:

Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits 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) statements 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:
Unitd States Office of Personnel Management
Ofice of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- 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, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.

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.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more, and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. **Ask questions if you have doubts or concerns.**

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.

- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. **Get the results of any test or procedure.**

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. **Talk to your doctor about which hospital is best for your health needs.**

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. **Make sure you understand what will happen if you need surgery .**

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

  Exactly what will you be doing?

  About how long will it take?

  What will happen after surgery?

  How can I expect to feel during recovery?

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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.

General features of our Plan

We have a Preferred Provider Organization (PPO):

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are "preferred providers". When you use our PPO providers, you will receive covered services at reduced cost. CIGNA HealthCare is solely responsible for the selection of PPO providers in your area. Call 1-877-220-NALC (6252) for the names of PPO providers or call us at 703-729-4677 or 1-888-636-NALC (6252) to request a PPO directory. We recommend that you call the PPO provider you select before each visit and verify they continue to participate in the CIGNA HealthCare Shared Administration PPO Network. 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 standard non-PPO benefits apply. However, if the surgical services (including maternity) are rendered at a PPO hospital by a PPO physician, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level. In addition, we will pay medical emergencies specifically listed in Section 5(d). *Medical emergency* at the PPO benefit level.

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 share the savings with you.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (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 health plan sponsored and administered by the National Association of Letter Carriers (NALC), AFL-CIO.
- Our preferred provider organization (PPO) is CIGNA HealthCare Shared Administration PPO Network.
- Our network provider for mental health and substance abuse benefits is OptumHealth**SM** Behavioral Solutions (comprised of United Behavioral Health, a UnitedHealth Group company).
- Our prescription drug retail network is the NALC CareSelect Network.
- Our mail order prescription program and specialty pharmacy services are 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 Web site at www.nalc.org/depart/hbp.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

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 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; or in response to a subpoena, discovery request, or other lawful process. Before we release PHI in response to a subpoena, discovery request, or other legal process not accompanied by a court order, we will require certain written assurances from the party seeking the PHI, consistent with the requirements of the HIPAA Privacy Regulations.
- For Law Enforcement: We may disclose your PHI to a law enforcement official as part of certain law enforcement activities.
- 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 United States 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 PHI. We will mail our explanation of benefits (EOB) statements and other payment-related materials to the enrollee. However, if you believe disclosure of your protected health information could result in harm to yourself or others, you have the right to request to receive confidential communications of PHI at an alternative address. Send your written request to our Privacy Official at the address listed at the end of this Notice. In the request, you must tell us (1) the address to which we should mail your PHI, and (2) that the disclosure of all or part of your PHI to an address other than the one you provided could endanger you or others. If we can accommodate your request, we will.
- 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 United States 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 Member Services 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 January 1, 2009.

Section 2. How we change for 2009

Do not rely only 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

- In Section 3, under Covered providers, Illinois has been added to the list of medically underserved areas for 2009.

Changes to this Plan

- Your share of the NALC Postal premium will increase for Self Only and increase for Self and Family. (see page 89)
- Your share of the non-Postal premium will decrease for Self Only and increase for Self and Family. (see page 89)
- We added a $4,000 catastrophic protection out-of-pocket maximum for retail prescription drugs. (see page 20)
- You now pay $15 for office or outpatient visits rendered by a PPO provider. Previously, you paid $20. (see page 25)
- You now pay $15 for office or outpatient consultations rendered by a PPO provider. Previously, you paid 15%. (see page 25)
- You now pay 10% for covered services rendered by PPO physicians and other health care professionals. Previously, you paid 15%. (see page 25)
- You now pay 25% for covered services rendered by non-PPO physicians and other health care professionals. Previously, you paid 30%. (see page 25)
- We no longer apply the PPO calendar year deductible to covered adult preventive care services rendered by a PPO provider. Previously, the PPO calendar year deductible applied. (see page 26)
- You now pay nothing for adult preventive immunizations and screenings rendered by a PPO physician. Previously, you paid 10% or 15%. (see page 26)
- We now cover a routine general health panel blood test, basic or comprehensive metabolic panel blood test, complete blood count (CBC), urinalysis, electrocardiogram (ECG/EKG), and chest x-ray for adults, one annually. (see page 27)
- We now cover an annual pneumococcal vaccine for adults with medical indications as recommended by the CDC. (see page 26)
- We now cover a routine annual mammogram for women ages 65 and older. Previously, we covered one every two (2) consecutive calendar years. (see page 28)
- We now cover an annual routine physical (including camp, school, and sports physicals) for children ages 3 through 21. (see page 28)
- You now pay a $15 copayment for each physical, occupational, or speech therapy visit rendered by a PPO provider. Previously, you paid 15%. (see page 32)
- We now limit physical, occupational and speech therapy to a combined total of 75 visits per calendar year. Previously, our limitation was 50 physical and occupational therapy visits (combined) and 30 speech therapy visits per calendar year. (see page 32)
- We now cover a hearing aid and related examination for neurosensoral hearing loss, with a maximum payment of $1,000 per lifetime. (see page 32)
- You now pay only a $100 copayment per admission for non-maternity inpatient room and board and other hospital services and supplies in a PPO hospital. Previously, you paid 10% for other hospital services and supplies in a PPO hospital. (see page 46)
- You now pay nothing for immobilization by casting of a sprain, strain, or fracture, and simple repair of a laceration (stitches) when you receive care within 72 hours of an accidental injury. Previously, when you used a PPO provider, you paid 10% of Plan allowance for the surgery and 15% of Plan allowance for the outpatient facility. If you used a non-PPO provider then you previously paid 30%. (see page 51)

- You can now purchase up to a 90-day supply of covered drugs and supplies at a local CVS/Caremark pharmacy and you pay our applicable mail order copayment. Previously, you had to utilize our Mail Order Prescription Drug Program to receive the Plan's maximum prescription benefit. (see page 60)
- We now cover prescription medications for smoking cessation. (see page 60)
- We now cover dental care necessary to repair sound natural teeth resulting from an accidental injury when treatment is obtained within 72 hours. (see page 61)
- We now offer a Weight Management Program that offers guidance and information to create an individual living plan that will lead to a healthy weight for life. (see page 63)

Clarifications

- We updated our information on accreditations. (see front cover)
- We updated our list of covered providers. (see page 14)
- We updated our definition of a freestanding ambulatory facility. (see page 14)
- We clarified that the Herpes Zoster (shingles) vaccine can be purchased at a local Preferred Network or NALC CareSelect Network pharmacy. (see page 27)
- We clarified that we would cover a varicella (chickenpox) vaccine for adults age 19 and older. (see page 27)
- We clarified that osteoporosis screening is covered for all women age 60 and older. (see page 27)
- We clarified that we cover medically necessary maternity tests. (see page 29)
- We clarified that we only cover a standard intraocular lens prosthesis, such as for cataract surgery. (see page 39)
- We updated the address for filing Caremark paper claims. (see page 59)
- We updated the address for obtaining mail order prescriptions from Caremark. (see page 58)
- We added Healthy Rewards to our Special features. (see page 63)
- We clarified how to file a claim. (see page 67)

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 Plan 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 electronic enrollment system (such as Employee Express) confirmation letter. If you want to obtain a prescription at an NALC CareSelect retail pharmacy and have not received your identification card, call 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 licenses 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.), podiatrist (D.P.M.), or chiropractor (D.C.).
- 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.

Note: We allow charges when billed independently by nurse practitioners and physician assistants as allowed by state licensure laws.

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved." For 2009, the states are Alabama, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, 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), Accreditation Association of Ambulatory Health Care (AAAHC), American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF), American Osteopathic Association (AOA), 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 hours 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 hours 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 (except as listed in Section 5(e). *Mental health and substance abuse—In-Network Benefits*).
- **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 reasons other than for 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 your PPO benefits continue until the end of your postpartum care, even if it is beyond the 90 days.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Services department immediately at 703-729-4677 or 1-888-636-NALC (6252). If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

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.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that your care is precertified, 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. If the stay is not medically necessary, we will not pay any benefits.

- **How to precertify an admission**

  - You, your representative, your physician, or your hospital must call us at 1-877-220-NALC (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 then 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 contacts 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, less the $500 penalty.
- 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 only pay for any covered medical supplies and services that are 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 did 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.
  - Medicare Part A is the primary payor for the hospital stay. If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payor and you **do** need precertification.

- **Other services** Other services require precertification, preauthorization, or prior approval.
  - Growth hormone therapy (GHT). See Section 5(a). *Treatment therapies*.
  - Certain specialty drugs, including biotech drugs. See Section 5(a). *Treatment therapies* and Section 5(f). *Prescription drug benefits*.
  - Organ/tissue transplants and donor expenses. See Section 5(b). *Organ/tissue transplants*.
  - Mental health and substance abuse care. See Section 5(e). *Mental health and substance abuse benefits*.
  - Durable medical equipment (DME). See Section 5(a). *Durable medical equipment*.

- **Exceptions:** You do not need precertification, preauthorization, or prior approval if you have another group health insurance—including Medicare—that is your primary payer.

Section 4. Your costs for covered services

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

Copayments

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

Example: When you see your PPO physician, you pay a $15 copayment per office visit, and when you are admitted to a non-PPO hospital, you pay $100 per admission.

Note: If the billed amount or the Plan allowance that a PPO provider agrees to accept as payment in full is less than your copayment, you pay the lower amount.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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 and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible. Your copayments, excluding prescription drugs, **do** count toward your out-of-pocket maximum.

- 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.

If the billed amount or the Plan allowance that a PPO provider agrees to accept as payment in full is less than your copayment, or less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your calendar year deductible ($250) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, 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 25% of our allowance for office visits.

If your provider routinely waives your cost

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 25% coinsurance, the actual charge is $75. We will pay $56.25 (75% of the actual charge of $75).

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that CIGNA HealthCare has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 1-888-636-NALC (6252).

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 10% of our $100 allowance ($10). 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 25% of our $100 allowance ($25). Plus, because there is no agreement between the non-PPO physician and us, the physician 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	90% of our allowance: 90	75% of our allowance: 75
You owe: Coinsurance	10% of our allowance: 10	25% of our allowance: 25
+Difference up to charge	No: 0	Yes: 50
TOTAL YOU PAY	$10	$75

Your catastrophic protection out-of-pocket maximum for deductible, coinsurance and copayments

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:

- $4000 per person or family for services of PPO providers/facilities.
- $6000 per person or family for services of PPO and non-PPO providers/facilities, combined.
- Coinsurances for prescription drugs dispensed by an NALC CareSelect Network pharmacy count toward a $4000 annual retail prescription out-of-pocket maximum excluding the following amounts:
  - The 50% coinsurance for prescriptions purchased at a non-network pharmacy.
  - Any associated costs when you purchase medications in excess of the Plan's dispensing limitations.
  - The difference in cost between a brand name and a generic drug when you elect to purchase the brand name, and a generic drug is available, and your physician has not specified "Dispense as Written".

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:

- $4000 per person or family for services of PPO 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
- Any out-of-network outpatient mental health and substance abuse professional care

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

- 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.

Carryover

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

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 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.

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

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. 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 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) statement that we send you; and
- the law prohibits a hospital from collecting more than the "equivalent Medicare amount".

And, for your physician care, the law requires us to base our payment and your coinsurance or copayment 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 assignmentment for the claim—whether the physician participates in our PPO network or not,	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) statement 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.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you if Medicare is primary since Medicare does not pay the VA facility.

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 covers.

- 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.

It's important to know that a 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 the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

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

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. In these instances, our payment will be based on our non-PPO Plan allowance.

When you have Medicare prescription drug coverage (Part D)

When Medicare Part D is primary payer and covers the drug, you will never pay more than the Plan's Medicare prescription drug copayment or coinsurance.

When the drug is not covered by Medicare Part D, 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 12 for how our benefits changed this year and page 86 for a benefits summary.)

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

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, and pathologists, may **not** all be preferred providers. If they are not, they will be paid as non-PPO providers.
- When surgical services (including maternity) are rendered at a PPO hospital by a PPO physician, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level.
- 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 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay After 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 or urgent care centers • Office or outpatient visits • Office or outpatient consultations	PPO: $15 copayment per visit (No deductible) Non-PPO: 25% 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 • Inpatient medical consultations • Second surgical opinions • Home visits Note: For routine post-operative surgical care, see Section 5(b). *Surgical procedures.*	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Routine eye and hearing examinations (except as listed in* Preventive care, children *and* Hearing services... *in this section)*	*All charges*

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After calendar year deductible
Diagnostic and treatment services (cont.)	
• *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) • Osteoporosis screening Note: When tests are performed during an inpatient confinement, no deductible applies.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
If Quest Diagnostics performs your covered lab services, you will have no out-of-pocket expense and you will not have to file a claim. Ask your doctor to use Quest for lab processing. To find a location near you, call 1-877-220-NALC (6252), or visit our Web site at www.nalc.org/depart/hbp.	Nothing (No deductible)
Not covered: Routine tests, except listed under Preventive care, adult *in this section.*	*All charges*
Preventive care, adult	
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC), limited to: • Herpes Zoster (shingles) vaccine—adults age 60 and older • Human Papillomavirus (HPV) vaccine—adult women age 26 and younger • Influenza vaccine—one per flu season • Measles, Mumps, Rubella (MMR)—age 19 through 49 (except as provided for under *Preventive care*, *children* in this section) • Pneumococcal vaccine— - age 19 through 64 with medical indications as recommended by the CDC - age 65 and older	PPO: Nothing (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay After calendar year deductible
Preventive care, adult (cont.)	
• Tetanus-diphtheria (Td) booster—one every 10 years, age 19 and older (except as provided for under *Preventive care, children* in this section) • Tetanus-diphtheria, pertussis (Tdap) booster—one, age 19 through 64 (except as provided for under *Preventive care, children* in this section) • Varicella (chickenpox) vaccine—adults age 19 and older Note: Herpes Zoster (shingles) vaccine is available at local Preferred Network or NALC CareSelect Network pharmacies. Call us at 703-729-4677 or 1-888-636-NALC (6252) prior to purchasing this vaccine at your local pharmacy. 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 • Diabetes screening—two fasting blood sugar tests every 3 years • Human Immunodeficiency Virus (HIV)—one annually • General health panel blood test—one annually • Basic or comprehensive metabolic panel blood test —one annually • Complete blood count (CBC)—one annually • Urinalysis—one annually • Electrocardiogram (ECG/EKG)—one annually • Chest x-ray—one annually • Abdominal aortic aneurysm screening by ultrasonography—one in a lifetime, for men ages 65 through 75 with smoking history • Osteoporosis screening—for women age 60 and older	PPO: Nothing (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay After calendar year deductible
Preventive care, adult (cont.)	
• Mammogram—for women age 35 and older, as follows: - Ages 35 through 39—one during this five year period - Ages 40 and older—one every calendar year • 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 Note: To reduce your out-of-pocket costs for laboratory services use Quest Diagnostics, see *Lab, x-ray, and other diagnostic tests* in this section.	PPO: Nothing (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Sigmoidoscopy screening—one every five years, age 50 and older • Colonoscopy screening—one every 10 years, age 50 and older	PPO: Nothing (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between the Plan allowance and the billed amount
Routine physical exam—one annually, age 22 or older	PPO: $15 copayment per visit (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between the Plan allowance and the billed amount
Not covered: Routine lab tests, except listed under Preventive care, adult *in this section.*	*All charges*
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 • Well-child care—routine examinations and immunizations through age 2 • Newborn screening hearing test—one per lifetime 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: - Routine physical exam (including camp, school, and sports physicals)—one annually, age 3 through 21 - 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: $15 copayment per visit (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, children - continued on next page

Benefit Description	You pay After calendar year deductible
Preventive care, children (cont.)	
Not covered: • *Routine hearing testing (except as listed in* Preventive care, children *and* Hearing services... *in this section)* • *Hearing aid and examination, except as listed in* Hearing services... *in this section*	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • Amniocentesis • Anesthesia	PPO: Nothing (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Group B streptococcus infection screening • Sonograms • Fetal monitoring • Other tests medically indicated for the unborn child or as part of the maternity care 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. • 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, anesthesia, and surgeon services (delivery) at 100% of Plan allowance when you use a PPO provider. See Section 5(c). *Inpatient hospital* and Section 5(b). *Surgical procedures*. • To reduce your out-of-pocket costs for laboratory services use Quest Diagnostics, see *Lab, x-ray, and other diagnostic tests* in this section.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Benefit Description	You pay After calendar year deductible
Family planning	
Voluntary family planning services, limited to: • Voluntary sterilization (see Section 5(b). *Surgical procedures*) • Implanted contraceptives • Insertion of intrauterine devices (IUDs)	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Injectable contraceptive drugs (such as Depo provera) • Diaphragms • Intrauterine devices Note: We cover oral contraceptives only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits.*	PPO: 10% of the Plan allowance Non-PPO: 25% 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: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures such as:* - *Artificial insemination* - *In vitro fertilization* - *Embryo transfer and gamete intrafallopian transfer (GIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Benefit Description	You pay After calendar year deductible
Allergy care	
• Testing • Treatment, except for allergy injections • Allergy serum	PPO: 10% of the Plan allowance Non-PPO: 25% 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: 25% 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	
• Intravenous (IV)/Infusion Therapy—Home IV and antibiotic therapy • Respiratory and inhalation therapies • Growth hormone therapy (GHT) Note: Specialty drugs, including biotech drugs, available through Caremark Specialty Pharmacy Services are covered only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits.* Note: Prior approval is required for certain specialty drugs used to treat chronic medical conditions, such as allergic asthma, hepatitis C, psoriasis, growth hormone disorder, rheumatoid arthritis, and respiratory syncytial virus (RSV). See instructions for approval in Section 5(f). *Prescription drug benefits—These are the dispensing limitations.* • Dialysis—hemodialysis and peritoneal dialysis • 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.* Note: Oral chemotherapy drugs available through Caremark are covered only under the Prescription drug benefit. Section 5(f). *Prescription drug benefits—These are the dispensing limitations.*	PPO: 10% of the Plan allowance Non-PPO: 25% 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*

Benefit Description	You pay After calendar year deductible
Physical, occupational, and speech therapies	
• A combined total of 75 visits per calendar year for treatment provided by a licensed registered therapist or physician for the following: - Physical therapy - Occupational therapy - Speech 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. Note: For accidental injuries, see Section 5(d). *Emergency services/accidents*. Note: For therapies performed on the same day as outpatient surgery, see Section 5(c). *Outpatient hospital or ambulatory surgical center*.	PPO: $15 copayment per visit (no deductible) and all charges after 75 visit limit Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after 75 visit limit
• Cardiac rehabilitation therapy	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Exercise programs* • *Maintenance therapy that maintains a functional status or prevents decline in function*	*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: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Hearing aid and related examination for neurosensoral hearing loss limited to a maximum Plan payment of $1000 per lifetime	PPO: 10% of the Plan allowance and all charges after we pay $1000 per lifetime Non-PPO: 25% of the Plan allowance and all charges after we pay $1000 per lifetime

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay After calendar year deductible
Hearing services (testing, treatment, and supplies) (cont.)	
Not covered: • *Routine hearing testing (except as listed in* Preventive care, children *and* Hearing services... *in this section)* • *Hearing aid and examination, except as described above* • *Auditory device except as described above*	*All charges*
Vision services (testing, treatment, and supplies)	
• Eye examinations for covered diagnoses, such as cataract, diabetic retinopathy and glaucoma	PPO: $15 copayment per visit (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) when purchased within one year Note: We only cover the standard intraocular lens prosthesis, such as for cataract surgery. Note: For examinations for amblyopia and strabismus, see *Preventive care, children* in this section.	PPO: 10% of the Plan allowance Non-PPO: 25% 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, except as described above* • *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: 10% of the Plan allowance Non-PPO: 25% 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 • Extracorporeal shock wave treatment (when symptoms have existed for at least 6 months and other standard methods of treatment have been unsuccessful)	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered:	*All charges*

Foot care - continued on next page

Benefit Description	You pay After calendar year deductible
Foot care (cont.)	
• *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; bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotics (shoe inserts) except as listed under* Orthopedic and prosthetic devices *in this section* • *Arch supports, heel pads, and heel 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*. Note: We only cover the standard intraocular lens prosthesis, such as for cataract surgery.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• One pair of custom functional foot orthotics every 5 years when prescribed by a physician (with a maximum Plan payment of $400).	PPO: 10% of the Plan allowance and all charges after we pay $400 Non-PPO: 25% of the Plan allowance and all charges after we pay $400
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics (shoe inserts) except as listed under* Orthopedic and prosthetic devices *in this section* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Bionic prosthetics* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*

Benefit Description	You pay After calendar year deductible
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. Note: Call us at 703-729-4677 or 1-888-636-NALC (6252) as soon as your physician prescribes equipment or supplies. We cover rental or purchase (at our option) including repair and adjustment of durable medical equipment, such as: • Oxygen and oxygen apparatus • Dialysis equipment • 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	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *DME replacements (including rental) 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*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After calendar year deductible
Durable medical equipment (DME) (cont.)	
• *Stair climbing equipment, stair glides, ramps, and elevators* • *Modifications or alterations to vehicles or households* • *Equipment or devices, such as iBOT Mobility System that allow increased mobility, beyond what is provided by standard features of DME* • *Other items (such as wigs) that do not meet the criteria 1 thru 6 on page 35.*	*All charges*
Home health services	
Up to 50 days per calendar year (with a maximum Plan payment of $135 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: 10% of the Plan allowance (No deductible) and all charges after we pay $135 per day Non-PPO: 25% of the Plan allowance (No deductible) and all charges after we pay $135 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	
Limited to: • Initial set of spinal x-rays • 12 spinal manipulations per calendar year Note: The above services rendered by a chiropractor in medically underserved areas are subject to these limitations. Benefits may be available for other covered services you receive from a chiropractor in medically underserved areas.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Limited to: • Initial office visit or consultation	PPO: $15 copayment per visit (No deductible) Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Any treatment not specifically listed as covered	*All charges*

Benefit Description	You pay After calendar year deductible
Alternative treatments	
Acupuncture, limited to treatment by a doctor of medicine or osteopathy for pain relief	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
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 through United HealthCare's QuitPower® program which includes: - Professional counseling via telephone - Online support - Eight week supply of over-the-counter nicotine replacement therapy - Educational articles, quizzes, and progress tracking tools To join call1-877-QUIT-PWR (1-877-784-8797) or log on to our web site at www.nalc.org/depart/hbp and select the OptumHealth Solutions Resource from our Health Center tab. Note: Prescription medications for smoking cessation are covered only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits.*	Nothing for services obtained through United HealthCare's QuitPower® program (No deductible)
• Educational classes and nutritional therapy for self-management of diabetes when: - Prescribed by the attending physician, and - Administered by a covered provider, such as a registered nurse or a licensed or registered dietician/nutritionist.	PPO: 10% of the Plan allowance Non-PPO: 25% 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 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, and pathologists, may **not** all be preferred providers. If they are not, they will be paid as non-PPO providers.
- When surgical services (including maternity) are rendered at a PPO hospital by a PPO physician, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level.
- 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 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 APPROVAL FOR ORGAN/TISSUE TRANSPLANTS**. See Section 5(b). *Organ/tissue transplants*.

Benefit Description	You pay
Note: The calendar year deductible applies ONLY when we say, "(calendar year deductible applies)."	
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 • Removal of tumors and cysts • Correction of congenital anomalies	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• Surgical treatment of morbid obesity (bariatric surgery) is covered when: 1. Clinical records support a body mass index (BMI) of 40 or greater, or 35 or greater with high-risk comorbid conditions such as serious cardiopulmonary problems or severe diabetes mellitus. 2. The patient has participated in a physician-supervised weight-loss program, of at least six months duration, that includes dietary therapy, physical activity and behavior modification. This physician supervised program must be documented in the medical records and have occurred within a reasonable time period prior to the surgery. 3. A repeat or revised bariatric surgical procedure is covered only when medically necessary or a complication has occurred, such as a fistula, obstruction, or disruption of a suture/staple line. 4. The patient is 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 • 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. Note: Simple repair of a laceration (stitches) and immobilization by casting of a sprain, strain, or fracture, will be considered under this benefit when services are rendered after 72 hours of the accident. Note: We only cover the standard intraocular lens prosthesis for cataract surgery.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone), except as listed in Section 5(g).* Dental benefits • *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	
• 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; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedemas	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
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: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
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: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except as listed in Section 5(g).* Dental benefits	*All charges*

Benefit Description	You pay
Organ/tissue transplants	
Solid organ transplants limited to: • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	Nothing for services obtained through the CIGNA LIFESOURCE Transplant Network® PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Blood or marrow stem cell transplants limited to the stages of the following diagnoses (Note: The medical necessity limitation is considered satisfied, if the patient meets the staging description): • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/ small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Hemoglobmopathy (i.e. Fanconi's, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for: - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma	Nothing for services obtained through the CIGNA LIFESOURCE Transplant Network® PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- De-novo myeloma Blood or marrow stem cell transplants limited to: • Allogeneic transplants for: - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - X-linked lymphoproliferative syndrome • Autologous transplants for: - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer	Nothing for services obtained through the CIGNA LIFESOURCE Transplant Network® PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Blood or marrow stem cell transplants covered only in a National Cancer Institute (NCI) or National Institutes of Health (NIH) approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols limited to: • Autologous transplants for: - Breast cancer - Epithelial ovarian cancer	Nothing for services obtained through the CIGNA LIFESOURCE Transplant Network® (No deductible)
Mini-transplants (non-myeloablative, reduced intensity conditioning) for covered transplants: Subject to medical necessity	Nothing for services obtained through the CIGNA LIFESOURCE Transplant Network® PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Tandem transplants for covered transplants: Subject to medical necessity	Nothing for services obtained through the CIGNA LIFESOURCE Transplant Network® PPO: 10% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
	Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
CIGNA LIFESOURCE Transplant Network®—The Plan participates in the CIGNA LIFESOURCE Transplant Network®. Before your initial evaluation as a potential candidate for a transplant procedure, you or your physician must contact CIGNA Healthcare at 1-800-668-9682 and speak to a referral specialist in the Comprehensive Transplant Case Management Unit. You will be given information about this program including a list of participating providers. Charges for services performed by a CIGNA LIFESOURCE Transplant Network® 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 CIGNA LIFESOURCE Transplant Network®
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* in this section. The limitation applies to expenses incurred by either the recipient or donor. Note: Some transplants listed may not be covered through the CIGNA LIFESOURCE Transplant Network®. 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: 25% 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*

Benefit Description	You pay
Anesthesia	
Professional services provided in: • Hospital (inpatient) Note: If surgical services (including maternity) are rendered at a PPO hospital by a PPO physician, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level.	PPO: Nothing when services are related to the delivery of a newborn. 10% of the Plan allowance for anesthesia services for all other conditions. Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Professional services provided in: • Hospital outpatient department • Ambulatory surgical center • Office • Other outpatient facility Note: If surgical services are rendered at a PPO hospital by a PPO physician, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level.	PPO: 10% of the Plan allowance (calendar year deductible applies) Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

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

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 5(a) and (b), the calendar year deductible applies to only a few benefits. In that case, we say "(calendar year deductible 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, and pathologists, may **not** all be preferred providers. If they are not, they will be paid as non-PPO providers.
- When surgical services (including maternity) are rendered at a PPO hospital by a PPO physician, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level.
- 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.

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

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
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 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 nor the anesthesia service when billed by the anesthesiologist. 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: Nothing when services are related to the delivery of a newborn. $100 copayment per admission for all other admissions. 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

Benefit Description	You pay
Inpatient hospital (cont.)	
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 • Physical, occupational, and speech therapy (when surgery performed on the same day) Note: When surgery is not performed on the same day, see Section 5(a). *Physical, occupational, and speech therapies* for coverage of these therapies. Note: For accidental injuries, see Section 5(d). *Emergency services/accidents.* For accidental dental injuries, see Section 5(g). *Dental benefits.*	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)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center (cont.)	
Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental physical impairment or as the result of an accidental dental injury as defined in Section 5(g). *Dental benefits.* We do not cover the dental procedures or the anesthesia service when billed by the anesthesiologist.	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: To reduce your out-of-pocket costs for laboratory services use Quest Diagnostics, see Section 5(a). *Lab, x-ray and other diagnostic tests.* 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, and the difference, if any, between our allowance and the billed amount
Not covered: Personal comfort items	*All charges*
Extended care benefits/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, for the first 30 days of each admission or readmission to a facility, 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*

Benefit Description	You pay
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	
• Professional ambulance service to an outpatient hospital or ambulatory surgical center	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)
• Professional ambulance service to the nearest inpatient hospital equipped to handle your condition	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: Transportation (other than professional ambulance services), such as by ambulette or medicab	*All charges*

Section 5(d). Emergency services/accidents

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, except as listed within this Section.
- 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, and pathologists, may **not** all be preferred providers. If they are not, they will be paid as non-PPO providers.
- When surgical services (including maternity) are rendered at a PPO hospital by a PPO physician, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level.
- 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*.

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means.

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: • Simple repair of a laceration (stitches) and immobilization by casting of a sprain, strain, or fracture • Related nonsurgical office or outpatient services and supplies • Local professional ambulance service when medically necessary Note: For surgeries related to your accidental injury not listed above, see Section 5(b). *Surgical procedures*. Note: For dental benefits for accidental injury, see Section 5(g). *Dental benefits*.	PPO: Nothing (No deductible) Non-PPO: The difference, if any, between the Plan allowance and the billed amount (No deductible)

Benefit Description	You pay After the calendar year deductible…
Accidental Injury (cont.)	
Services received after 72 hours	Medical and outpatient hospital benefits apply. See Section 5(a). *Medical services and supplies provided by physicians and other health care professionals,* Section 5(b). *Surgical and anesthesia services provided by physicians and other health care professionals* and Section 5(c). *Outpatient hospital or ambulatory surgical center* for the benefits we provide.
Medical emergency	
Outpatient medical services and supplies except physicians' and urgent care center office visits. See Section 5(a). *Diagnostic and treatment services.* Note: Outpatient services rendered by a non-PPO hospital for the initial treatment of an automobile accident, acute myocardial infarction, or concussion will be paid at the PPO benefit level.	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
Professional services of physicians and urgent care centers • Office or outpatient visits • Office or outpatient consultations	PPO: $15 copayment per visit (No deductible) Non-PPO: 25% 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: 25% 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

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.

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 or covered services are not preauthorized, 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 FOR 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 56.

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 $15 copayment per office visit, or 10% of the Plan allowance for other services (except for outpatient hospital) 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	$15 copayment per visit (No deductible)
• Outpatient diagnostic tests	15% of the Plan allowance
• Inpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Lab and other diagnostic tests performed in an office or urgent care setting	10% of the Plan allowance

In-Network benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
In-Network benefits (cont.)	
• Inpatient room and board provided by a hospital or other facility	$100 copayment per admission (No deductible)
• Other inpatient services and supplies provided by: - Hospital or other facility - Approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$100 copayment per admission (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:

OptumHealth Behavioral Solutions 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 OptumHealth Behavioral Solutions for the initial and any ongoing authorizations.

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. OptumHealth Behavioral Solutions' network providers are responsible for filing. Claims should be submitted to:

OptumHealth Behavioral Solutions
P.O. Box 30755
Salt Lake City, UT 84130-0755
Questions? 1-877-468-1016

Section 5(e). Mental health and substance abuse benefits - Out-of-Network Benefits

You may choose to get care In-Network or Out-of-Network.

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 7. *Filing a claim for covered services* and 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.

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
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*	*All charges*

Out-of-Network benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Out-of-Network benefits (cont.)	
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, benefits will be reduced by $500. See Section 3 for details.

Where to file claims

OptumHealth Behavioral Solutions
P.O. Box 30755
Salt Lake City, UT 84130-0755
Questions? 1-877-468-1016

Section 5(f). Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed medications and supplies as described in the chart beginning on page 60.
- 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 drug deductible of $25 per person or $50 per family applies only to non-network benefits. The calendar year deductible applies ONLY when we say "(calendar year deductible applies)."
- **SOME DRUGS REQUIRE PRIOR APPROVAL** before we provide benefits for them. Refer to the dispensing limitations on this page for further information.
- Maximum dosage dispensed may be limited by protocols established by the Plan.
- In the event of a disaster or an emergency where additional or early fills of medications are needed, call the Plan at 703-729-4677 or 1-888-636-NALC (6252) for authorization.
- When we say "Medicare" in the *You pay* section we mean you have Medicare Part B or Part D 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*.

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

- **Who can write your prescription.** Any provider licensed to prescribe drugs may write your prescription.
- **Where you can obtain them.** You may fill the prescription at a preferred network pharmacy, network pharmacy, a non-network pharmacy, or by mail. We provide a higher level of benefits when you purchase your generic drug through our mail order program.
  - **Preferred network pharmacy**—For added savings, purchase your prescription drugs at an NALC Preferred Network pharmacy. We have negotiated with a select group of retail pharmacies that offer a higher savings for your short-term prescriptions. Call 1-800-933-NALC (6252) to locate the nearest preferred network pharmacy.
  - **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 it along with your prescription(s) and payment, in the preaddressed envelope to:

    NALC Prescription Drug Program
    P.O. Box 94467
    Palatine, IL 60094-4467

- **We use a formulary.** Our formulary is open and voluntary. If your physician believes a brand name drug is necessary, or if there is no generic available, ask your physician to prescribe a brand name drug from our formulary list. These preferred brand name drugs are selected to meet patient needs at a lower cost. To order the formulary pamphlet, call 1-800-933-NALC (6252).
- **These are the dispensing limitations.** You may purchase up to a 90-day supply (84-day minimum) of covered drugs and supplies at a CVS/Caremark Pharmacy through our Maintenance Choice Program. You will pay the applicable mail order copayment for each prescription purchased. For prescriptions purchased at all other NALC Preferred Network pharmacies and NALC CareSelect pharmacies you may obtain up to a 30-day fill plus one refill. Maintenance and long-term medications may also be ordered through our Mail Order Prescription Drug Program for up to a 60-day or 90-day supply (21-day minimum). No deductible applies. You cannot obtain a refill until 75% of the drug has been used. Network retail pharmacy limitations are waived when you have Medicare Part D as your primary payer and they cover the drug.

You may obtain up to a 30-day fill and unlimited refills for each prescription purchased at a non-network retail pharmacy. When you use a non-network pharmacy, your cost sharing will be higher.

You should purchase specialty drugs, including biotech and oral chemotherapy drugs, through the Caremark Specialty Pharmacy Services program to receive the maximum benefit. Examples of specialty drugs are Cerezyme, Respigam, Baygam, Avonex, and Factor VIII. Call Caremark Specialty Pharmacy Services at 1-800-237-2767 for more information and a complete list.

Certain specialty drugs require **prior approval** to ensure appropriate treatment therapies for chronic complex conditions (such as allergic asthma, hepatitis C, psoriasis, growth hormone disorder, rheumatoid arthritis, and respiratory syncytial virus). Examples of these drugs are Xolair, Peg-Intron, Raptiva, Humatrope, Enbrel, and Synagis. Call Caremark Specialty Pharmacy Services at 1-800-237-2767 to obtain prior approval.

Decisions about prior approval are based on guidelines developed by physicians at the FDA or independent expert panels and are administered by Caremark's pharmacy experts. 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 brand name.** If you receive a brand name drug when a federally-approved generic drug is available, and your physician has not specified "Dispense as Written" for the brand name drug, you have to pay the difference in cost between the brand name 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 brand name is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic drug costs you—and us—less than a brand name drug.
- **When you have Medicare Part D.** We waive the following at retail when Medicare Part D is primary payer and covers the drug:
  - Refill limitations
  - Day supply
  - Calendar year drug deductible

  Note: See Section 9. *Coordinating benefits with other coverage,* for more information on Medicare Part D.
- **When you have to file a claim.** If you purchase prescriptions at a non-network pharmacy, foreign/overseas pharmacy, or elect to purchase additional refills at a preferred network pharmacy, other than at a CVS/Caremark Pharmacy, or 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 patient's name, 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 52192
Phoenix, AZ 85072-2192

Note: If you have questions about the Program, wish to locate a preferred network pharmacy, NALC CareSelect Network retail pharmacy, or need additional claim forms, call 1-800-933-NALC (6252) 24 hours a day, 7 days a week.

Benefit Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
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, when the dysfunction is caused by medically documented organic disease • Prenatal vitamins that by federal law of the United States require a physician's prescription for their purchase • Prescription medications for smoking cessation Note: You may purchase up to a 90-day supply (84-day minimum) of covered drugs and supplies at a CVS/Caremark Pharmacy through our Maintenance Choice Program. You will pay the applicable mail order copayment for each prescription purchased. Note: If there is no generic equivalent available, you pay the brand name copay.	Retail: • Preferred network/Network retail: 25% of cost • Non-network retail: 50% of the Plan allowance, and the difference, if any, between our allowance and the billed amount (calendar year deductible applies) Retail Medicare: • Preferred network/Network retail Medicare: 15% of cost • Non-network retail Medicare: 50% of the Plan allowance, and the difference, if any, between our allowance and the billed amount Mail order: • 60-day supply: $8 generic/$24 brand name • 90-day supply: $12 generic/$35 brand name Mail order Medicare: • 60-day supply: $7 generic/$20 brand name • 90-day supply: $10 generic/$30 brand name
Not covered: • *Drugs and supplies when prescribed for cosmetic purposes* • *Vitamins, nutrients, and food supplements, even when a physician prescribes or administers them, except as listed as covered* • *Over-the-counter medicines and supplies* *Note: See Section 5(h).* Special Features *for information on the CaremarkDirect Program where you may obtain non-covered medications at a discounted rate.*	*All charges*

Section 5(g). Dental benefits

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, except as listed within this Section.
- 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, and pathologists, may **not** all be preferred providers. If they are not, they will be paid as non-PPO providers.
- When surgical services (including maternity) are rendered at a PPO hospital by a PPO physician, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level.
- 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*.

What is an accidental dental injury?

An **accidental dental injury to a sound natural tooth** is an injury caused by an external force or element such as a blow or fall that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries.

What is a sound natural tooth?

A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, prosthetic or porcelain restoration, or treated by endodontics, or tooth implant is not considered a sound, natural tooth.

Benefit Description	You pay
Note: The calendar year deductible applies ONLY when we say, "(calendar year deductible applies)."	
Accidental Dental Injury Benefit	
We only cover outpatient dental treatment incurred and completed within 72 hours of an accidental injury. We provide benefits for services, supplies, or appliances for dental care necessary to repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Dental services not rendered or completed within 72 hours* • *Bridges, oral implants, dentures, crowns*	*All charges*

Section 5(h). Special features

Special feature	Description
CaremarkDirect Program	You can purchase non-covered drugs through the Caremark mail service pharmacy and receive the convenience, safety, and confidentiality you already benefit from with covered prescriptions. CaremarkDirect is offered at no additional charge to you. Using the mail service program for both covered and non-covered prescriptions will help ensure overall patient safety. CaremarkDirect is a value-added program that provides you with safe, convenient access to competitively priced, non-covered prescriptions, and certain over-the-counter drugs. You may call 1-800-933-NALC (6252), 24 hours a day, 7 days a week, for a complete listing of available medications and their cost.
Disease management programs	These programs offer a considerable amount of personalized attention from clinicians and program educators who 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 allergic asthma, chronic heart failure, coronary artery disease, coronary heart failure, chronic obstructive pulmonary disease, diabetes, growth hormone disorder, hepatitis C, psoriasis, rheumatoid arthritis, respiratory syncytial virus, transplants, and ulcers.
Enhanced Eldercare Services	For members or spouses that are caring for an elderly relative or disabled dependent, this program provides expert assistance from a Care Advocate, a registered nurse with geriatric, disability and community health experience. Your benefit gives you a bank of six free hours per calendar year, which may be used for any combination of the following services: • Evaluating the elder's/dependent's living situation • Identifying medical, social and home needs (present and future) • Recommending a personalized service plan for support, safety and care • Finding and arranging all necessary services • Monitoring care and adjusting the service plan when necessary Whether it's arranging transportation to doctors' appointments, explaining insurance options, having safety equipment installed, or coordinating care with multiple providers, the Care Advocate will help ensure that your elderly relative or disabled dependent maintains a safe, healthy lifestyle. You also have the option to purchase continuing services beyond the six hours offered. You may call 1-877-468-1016, 24 hours a day, 7 days a week, to access Enhanced Eldercare Services. Hours of operation are 8:00 a.m. to 8:30 p.m. (Pacific time), with a Care Advocate on call after hours and on weekends.
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. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • 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 except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Healthy Rewards Program	A program available to all members that provides discounts on services that are not usually covered by the Plan. You will receive discounts on weight management and nutrition services, fitness clubs, vision and hearing care, magazine subscriptions, and healthy lifestyle products. This program promotes wellness, good health, and healthy behaviors. For more information call 1-800-870-3470.
24-hour nurse line	Call CareAllies 24-Hour Nurse Line at 1-877-220-NALC (6252) to access a registered nurse 24 hours a day, 7 days a week. This nurse line seeks to influence consumer behavior by providing tools, education, counseling and support to help members make decisions with respect to their health and use of healthcare services. Consumers may contact a CareAllies registered nurse at any time of the day or night, for: • Answers to questions about medical conditions, diagnostic tests or treatments prescribed by their physicians, or other health or wellness topics • Assistance to determine the appropriate level of healthcare services (emergency room, doctor visit, self care, etc.) required to address a current symptom • Self care techniques for home care of minor symptoms • Referrals for case management or other appropriate services • Introduction to the online health resources available at www.nalc.org/depart/hbp
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.
Personal Health Record	Our Personal Health Record allows you to create and maintain a complete, comprehensive, and confidential medical record containing information on allergies, immunizations, medical providers, medications, past medical procedures, and more. Participation is voluntary and access is secured. To access, register at www.nalc.org/depart/hbp, log on and select the 'Personal Health Record' tab.
Services for deaf and hearing impaired	TTY lines are available for the following: CAREMARK: 1-800-238-1217 (prescription benefit information) OptumHealth Behavioral Solutions: 1-800-842-2479 (mental health and substance abuse information)
Weight Management Program	The CIGNA Healthy Steps to Weight Loss - Weight Management Program guides each person in creating their own tailored healthy living plan to help them eat right, participate in regular physical activity, and adopt habits that will lead to a healthy weight for life. The program is a non-diet approach to weight loss with an emphasis on changing habits. Each person seeking assistance with behavior change responds to treatment options in his or her own unique way. The program format is tailored to each individual's learning style and level of readiness to make a behavior change.

	Participants, with the guidance of a Wellness Coach, a trained health professional, may select the online mode or the telephone coaching model. The Wellness Coach assesses participants for their BMI, health status, motivation, self-efficacy, food choices, sleep patterns, stress level, and other relevant risk factors and co-morbidities as well as readiness to change. A toolkit is sent to each coaching program participant to assist him or her in achieving their plan goals. Individuals may register online at www.nalc.org/depart/hbp or by calling the toll-free number at 1-877-220-NALC (6252). A Wellness Coach is available Monday-Friday 8:00 a.m. to 8:00 p.m. and Saturday 8:00 a.m. to 5:00 p.m.
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(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 an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB plan deductibles or out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-888-636-NALC (6252).

CIGNA*Plus* Savings SM (discount dental program)

CIGNA*Plus* Savings SM is a discount dental program that provides members access to discounted fees with participating dental providers. **This program is available only to members, and their dependents, of the NALC Health Benefit Plan.** The monthly Self Only premium is $3.75 and $5.50 for Self and Family. This is a discount program and not insurance, and the member must pay the entire discounted charge for dental services. For additional information or to join call 1-877-521-0244 or visit www.cignaplussavings.com.

Hospital Plus (hospital indemnity)

Hospital Plus is a hospital indemnity policy available for purchase from the United States Letter Carriers Mutual Benefit Association. This policy may be purchased throughout the year and is not subject to the health benefit plan open season. **This 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 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 $100 a day, $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 $60 a day, $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 $36,500 (if a $100 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 and current benefits, 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.

Important Notice Regarding Membership Dues

The NALC Health Benefit Plan is an employee organization plan. Enrollees in the Plan must be members, or associate members, of the NALC. If you are a federal employee who is **not** a Postal Service employee, an annuitant, a survivor annuitant, a former spouse of a federal employee, or you are eligible for Temporary Continuation of Coverage (TCC) under the FEHB Program, you are required to become an associate member of the NALC. Associate members will be billed by the NALC for the $36 annual membership dues, except where exempt by law (survivor annuitant or someone who is eligible for coverage under Spouse Equity Law or TCC). The annual associate membership dues is in addition to your bi-weekly (or monthly) share of the health benefit premium. You will receive an invoice for payment of associate membership dues directly from the NALC unless you are exempt. This invoice must be paid promptly.

If you are a Postal Service employee, your regular membership dues are paid through authorized payroll deduction. Postal Service employees are not considered associate members.

Please note that your employing office will not verify whether you are a member of the organization when it accepts your Health Benefits Election Form enrolling you in the NALC Health Benefit Plan. However, your employing office should inform you that membership in the NALC is necessary to be an enrollee in the Plan.

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. There may be other exclusions and limitations listed in Section 5 of this brochure. **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 (see specific coverage for transplants in *Section 5(b)*);
- 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 or sexual inadequacy;
- 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, drugs, or supplies 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 CIGNA LIFESOURCE Transplant Network®);
- Dental services and supplies (except those oral surgical procedures listed in Section 5(b*). Oral and maxillofacial surgery*) and Section 5(g). *Dental benefits*;
- 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 Web site at www.nalc.org/depart/hbp.

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 703-729-4677 or 1-888-636-NALC (6252). When Medicare is not the primary payer, claims should be submitted directly to CIGNA at the address shown on the reverse side of your identification card.

Note: To file a mental health and substance abuse treatment claim, see Section 5(e). *Mental health and substance abuse benefits.*

Note: To file a claim when Medicare is the primary payer, see Section 9. *Coordinating benefits with other coverage - The Original Medicare Plan (Part A or Part B).*

When you must file a claim—such as for services you received overseas or when another group health plan is primary, or when you are seeing an Out-of-Network provider—submit it on the CMS-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 statement you received 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 by December 31 of the year after the year you received the service, 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.

Claims for prescription drugs and supplies purchased outside the U.S. must include receipts that show the prescription number, name of drug or supply, prescribing physician's name, date, charge, and name of pharmacy. Complete the short-term prescription claim form, attach the drug receipts and mail to the NALC Prescription Drug Program.

NALC Prescription Drug Program
P.O. Box 52196
Phoenix, AZ 85072-2196

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for 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 (see Section 3. *How to get approval for…*).

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; b) Send your request to us at: NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149; c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits statements.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); b) Write to you and maintain our denial—go to step 4; or c) 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: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 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 statements; • 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

- 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
- 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 Insurance Group 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 has coverage under any other health plan or has 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; and
- People with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage plans on page 73.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. Medicare Part A covers hospital stays, skilled nursing facility care and other expenses. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

Note: Please refer to page 21 for information about how we provide benefits when you are age 65 or older and do not have Medicare.

- **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.

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 not need 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 for covered charges. To find out if you need to do something to file a claim, 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 copayments for office or outpatient visits.
  - The 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.

- **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. You may be responsible for paying the difference between the billed amount and the amount we paid.

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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

  Suspended FEHB coverage to enroll in a Medicare Advantage: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

  When you have Medicare Part D, we will coordinate benefits with the Medicare Prescription Drug Plan. When we are the secondary payer, we will pay the lesser of the balance after Medicare pays or our drug benefit.

  See Section 4. *Your cost for covered services*, and Section 5(f). *Prescription drug benefits* for more information on Medicare Part D.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

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 TRICARE or CHAMPVA.

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 or pays its maximum benefit 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: If your illness or injury is caused by the act or omission of a third party, the Plan has the right to reimbursement of benefits paid on your behalf from any recovery made to you by a third party or third party's insurer. "Third party" means another person or organization. Our right to reimbursement is limited to the benefits we have paid or will pay to you or on your behalf related to 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 keep the Plan advised of developments in your claim and promptly notify us of any recovery you receive, whether in or out of court. You must reimburse us to the extent the Plan paid benefits. You have the right to retain any recovery that exceeds the amount of the Plan's subrogation claim.

We will pay benefits for your illness or injury provided you do not interfere with or take any action to prejudice our attempts to recover the amounts we have paid in benefits, and that you cooperate with us in obtaining reimbursement. If you do not seek damages from the third party, you must agree to let us seek damages on your behalf. We may require you to assign the proceeds of your claim or the right to take action against the third party in your name, and we may withhold payment of benefits until the assignment is provided. You must sign a subrogation agreement and provide us with any other relevant information about the claim if we ask you to do so. However, a subrogation agreement is not necessary to enforce the Plan's rights.

All payments from the third party must be used to reimburse the Plan for benefits paid, regardless of whether the recovery is by court order or by settlement, and regardless of how the recovery is characterized (i.e., pain and suffering). The Plan has the right of first reimbursement for the full amount of our claim from any recovery you receive, even if your total recovery does not fully compensate you for the full amount of damages claimed. In other words, unless we agree in writing to a reduction, you are required to reimburse the Plan in full for its claim even if you are not "made whole" for your loss. In addition, the Plan's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise. Any reduction of the Plan's claim for attorney's fees or costs related to the claim is subject to prior written approval by the Plan.

We may reduce subsequent benefit payments if we are not reimbursed for the benefits we paid pursuant to these subrogation/reimbursement guidelines.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP)

Some FEHB plans already cover some dental and vision services. Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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 cost 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.

Cost-sharing
Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

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 service

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:

- Our Plan allowance is based on the 80th percentile of data gathered from health care sources that compare charges of other providers for similar services in the same geographic area; or
- For medication charges, our allowance is based on the average wholesale price.

Out-of-Network mental health and substance abuse benefits:
Our allowance is based on the 80th percentile of data gathered from health care sources that compare charges of other providers for similar services in the same geographic area 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 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/health for enrollment information as well as:

  - Information on the FEHB Program and plans available to you;
  - A health plan comparison tool;
  - A list of agencies who participate in Employee Express;
  - A link to Employee Express; and
  - Information on and links to other electronic enrollment systems.

  Also, your employing or retirement office can answer your questions and give you a *Guide to Federal Benefits*, 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;
  - What happens when your enrollment ends; and
  - When the next Open Season for enrollment begins.

  We don't determine who is eligible for coverage and 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 family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status (divorce or 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 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 cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. 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. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. 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 will receive an additional 31 days of coverage, for no additional premium, when:

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

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy).

- **Upon divorce**

  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 provide health coverage for you. However, you may be eligible for your own FEHB coverage under either 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 Benefits 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 Web site, 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **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.

  For more information, 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.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period.

Vision insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY: 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

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

Summary of benefits for the NALC Health Benefit Plan - 2009

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: $15 copayment per office visit; $5 copayment per allergy injection; routine screening services and other nonsurgical services, 10% of our allowance Non-PPO: 25% of our allowance	25
Services provided by a hospital:		
• Inpatient	PPO: Nothing when services are related to the delivery of a newborn. $100 copayment per admission for all other admissions. Non-PPO: $100 copayment per admission and 30% of our allowance	46
• Outpatient	PPO: 15% of our allowance Non-PPO: 30% of our allowance	48
Emergency benefits:		
• Accidental injury	Within 72 hours: Nothing for nonsurgical outpatient care, simple repair of laceration and immobilization of sprain, strain or fracture After 72 hours: PPO: Regular cost sharing Non-PPO: Regular cost sharing	51 52
• Medical emergency	Regular cost sharing	52
Mental health and substance abuse treatment:	In-Network: Regular cost sharing Out-of-Network: Benefits are limited	53 56
Prescription drugs:		
• Retail pharmacy	Preferred Network/Network retail: 25% of cost Preferred Network/Network retail Medicare: 15% of cost Non-network retail: $25 deductible and 50% of our allowance Non-network retail Medicare: 50% of our allowance	60

Benefits	You pay	Page
• Mail order	Mail order: 60-day supply, $8 generic/$24 brand name Mail order: 90-day supply, $12 generic/$35 brand name Mail order Medicare: 60-day supply, $7 generic/$20 brand name Mail order Medicare: 90-day supply, $10 generic/ $30 brand name	60
Dental care:	All charges.	61
Special features:	• CaremarkDirect • Disease management programs • Eldercare Enhanced Services • Flexible benefits option • 24-hour nurse line • 24-hour help line for mental health and substance abuse • Personal Health Record • Services for deaf and hearing impaired • Weight Management Program • Worldwide coverage	62
Protection against catastrophic costs (out-of-pocket maximum)**:**	Services with coinsurance (excluding mental health and substance abuse care), nothing after your coinsurance expenses total: • $4000 for PPO providers/facilities • $6000 for Non-PPO providers/facilities. When you use a combination of PPO and Non-PPO providers your out-of-pocket expense will not exceed $6000. • Coinsurances for prescription drugs dispensed by an NALC CareSelect Network pharmacy count toward a $4000 annual retail prescription out-of-pocket maximum Mental health and substance abuse benefits, nothing after your coinsurance expenses total: • $4000 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.	20

Notes

2009 Rate Information for the NALC Health Benefit Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits 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 Guide to Benefits *for Career* UnitedStates Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	321	$155.66	$56.50	$337.26	$122.42	$179.45	$32.71
High Option Self and Family	322	$349.13	$116.37	$756.44	$252.14	$402.66	$62.84