



NALC Health Benefit Plan

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

2002

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

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

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



To become a member:

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

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



Joint Commission
on Accreditation of Healthcare Organizations



Enrollment codes for this Plan:

321 Self Only

322 Self and Family

Caremark Therapeutic Services and its 17 pharmacies are JCAHO accredited; United Behavioral Health is JCAHO accredited; and First Health's Clinical Management Services is URAC accredited. See the 2002 Guide for more information on accreditation.

Authorized for distribution by the:



**United States
Office of Personnel Management**
Retirement and Insurance Service
<http://www.opm.gov/insure>



RI 71-009

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Introduction

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 5. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

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

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

Inspector General Advisory

Stop health care fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 703/729-4677 or 1-888-636-NALC (6252) and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE—202/418-3300

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

- **Penalties for Fraud**

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

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

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers. We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

We also have Preferred Provider Organizations (PPO)

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

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

How we pay providers

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

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

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

Your Rights

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

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

If you want more information about us, call 703/729-4677 or 1-888-636-NALC (6252), or write to NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149-0001. You may also visit our website at www.nalc.org/depart/hbp.

Section 2. How we change for 2002

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

Program-wide changes

- Four states are added to the list of medically underserved areas: Georgia, Montana, North Dakota, and Texas. Louisiana is no longer medically underserved. (Section 3)
- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the NALC Postal premium will decrease by 15.5% for Self Only and decrease by 25.9% for Self and Family.
- Your share of the non-Postal premium will decrease by 6.4% for Self Only or 10.9% for Self and Family.
- We clarified the brochure to better explain that the non-PPO benefits are the standard benefits of this Plan, that PPO benefits apply only when you use a PPO provider, and that when no PPO provider is available, non-PPO benefits apply.
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover routine screening for chlamydial infection. (Section 5(a))
- We added meningococcal immunization coverage under Preventive care, children. (Section 5(a))
- Your PPO copayment for amblyopia and strabismus examinations is now \$20. Previously your copayment was \$15. (Section 5(a))
- Your charges for physical and occupational therapy are now covered up to a combined total of 50 visits per calendar year. Previously the Plan covered up to 90 visits for each. (Section 5(a))
- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- Your charges for speech therapy are now covered up to a total of 30 visits per calendar year. Previously the Plan covered up to 90 visits. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- Your hospital inpatient coinsurance is now 10% of the Plan allowance at PPO hospitals and 30% of the Plan allowance at non-PPO hospitals. Previously you paid nothing at PPO hospitals and 20% of the Plan allowance at non-PPO hospitals. (Section 5(c))
- We changed how we determine our Plan allowance for non-PPO benefits. In geographic areas where you have adequate access to a PPO provider but do not use one, our allowance is based on the average PPO negotiated rate for that region. (Section 10)
- If you do not have adequate access to a PPO provider, our Plan allowance will be based on the 80th percentile of data gathered by Ingenix, Inc. Previously it was based on the 90th percentile. (Section 10)

Section 3. How you get care

Identification cards

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

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

Where you get covered care

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

- **Covered providers**

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

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

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

Medically underserved areas. We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are “medically underserved.” For 2002, the states are: Alabama, Georgia, Idaho, Kentucky, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, and Wyoming.

- **Covered facilities**

Covered facilities include:

- **Birthing center:** A freestanding facility that provides comprehensive maternity care in a home-like atmosphere and is licensed or certified by the jurisdiction.
- **Hospice:** A facility that 1) provides care to the terminally ill; 2) is licensed or certified by the jurisdiction in which it operates; 3) is supervised by a staff of physicians (M.D. or D.O.) with at least one such physician on call 24 hours a day; 4) provides 24-hour-a-day nursing services under the direction of a registered nurse (R.N.) and has a full-time administrator; and 5) provides an ongoing quality assurance program.
- **Hospital:** 1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or 2) any other institution licensed as a hospital, operating under the supervision of a staff of physicians with 24-hour-a-day registered nursing service, and is primarily engaged in providing general inpatient acute care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities. All these facilities must be provided on its premises or under its control.

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

What you must do to get covered care

Transitional care

- **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.

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.

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

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

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

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

Hospital care

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

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

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

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

How to Get Approval for...

• Your hospital stay

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

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

Warning

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

How to precertify an admission

- You, your representative, your physician, or your hospital must call us at 1-800-622-6252 prior to admission, unless your admission is related to a mental health and substance abuse condition. In that case, call 1-877-468-1016.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
 - Enrollee's name and Member identification number;
 - Patient's name, birth date, and phone number;
 - Reason for hospitalization, and proposed treatment or surgery;
 - Name and phone number of admitting physician;
 - Name of hospital or facility; and
 - Number of planned days of confinement.

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

Maternity care

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

If your hospital stay needs to be extended

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

What happens when you do not follow the precertification rules

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

Exceptions

You do not need precertification in these cases:

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

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

• Other services

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

- Growth hormone therapy (GHT): We cover GHT only when we preauthorize the treatment. Call 1-800-433-NALC (6252) for preauthorization. See Section 5(a). *Treatment therapies.*
- Some drugs, such as those for sexual dysfunction, require prior authorization. Call us at 1-800-433-NALC (6252) for information.
- Organ/tissue transplants and donor expenses: The Plan participates in the **First Health** National Transplant Program. Before your initial evaluation as a potential candidate for a transplant procedure, you or your physician must contact **First Health** at 1-800-622-6252 and speak to a Transplant Case Manager. See Section 5(b). *Organ/tissue transplants.*
- Mental health and substance abuse care: United Behavioral Health (UBH) provides the Plan's mental health and substance abuse benefits. Call 1-877-468-1016 for preauthorization. See Section 5(e). *Mental health and substance abuse benefits.*
- Durable medical equipment (DME): Although DME does not require prior authorization, you should call us at 1-800-433-NALC (6252) before you purchase or rent DME so we can give you information on discounted rates. See Section 5(a). *Durable medical equipment.*

Section 4. Your costs for covered services

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

- **Copayments**

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

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

- **Deductible**

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

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

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

- **Coinsurance**

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

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

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

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

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

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

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

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

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

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

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

Your catastrophic protection out-of-pocket maximum for coinsurance

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

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

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

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

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

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

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

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

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

When government facilities bill us

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

If we overpay you

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

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

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

If you...

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When you have a Medicare private contract with a physician

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

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

Section 5. Benefits — OVERVIEW

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

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

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• Maternity care	• Durable medical equipment (DME)
• Family planning	• Home health services
• Infertility services	• Chiropractic
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Section 5(a). Medical services and supplies provided by physicians and other health care professionals

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

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

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Benefit Description	You pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • Office or outpatient visits 	PPO: \$20 copayment per visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Professional services of physicians <ul style="list-style-type: none"> • Hospital care • Skilled nursing facility care • Initial examination of a newborn child covered under a family enrollment • Medical consultations • Second surgical opinions • Home visits Note: For routine post-operative surgical care, see Section 5(b). <i>Surgical procedures</i> .	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
<i>Not covered:</i> <ul style="list-style-type: none"> • Routine physical checkups and related tests • Routine eye and hearing examinations • Services by chiropractors, except in those states designated as medically underserved areas • Nonsurgical treatment for weight reduction or obesity 	<i>All charges</i>

Lab, X-ray and other diagnostic tests	You pay
<p>Tests and their interpretation, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram (EKG) • Electroencephalogram (EEG) 	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p> <p>Note: When tests are performed during an inpatient confinement no deductible applies.</p>
<p>Plan pays for preadmission testing within 7 days of admission or outpatient surgery. Screening tests, limited to:</p> <ul style="list-style-type: none"> • Chest X-rays • Electrocardiograms • Urinalysis • Blood work <p><i>Note: Diagnostic tests, such as magnetic resonance imaging, throat cultures or similar studies are not considered as preadmission testing.</i></p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: 20% of the Plan allowance (No deductible), and the difference, if any, between our allowance and the billed amount</p>
<p><i>Not covered: Routine tests, except listed under Preventive care, adult in this Section</i></p>	<p><i>All charges</i></p>
Preventive care, adult	
<p>Routine screenings, limited to:</p> <ul style="list-style-type: none"> • Total blood cholesterol—one every three years • Chlamydial infection • Colorectal cancer screening, including <ul style="list-style-type: none"> — Fecal occult blood test—one annually, age 40 and older 	<p>PPO: \$5 copayment (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<p>— Routine Sigmoidoscopy, screening—one every five years, age 50 and older</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between the Plan allowance and the billed amount</p>
<ul style="list-style-type: none"> • Routine Prostate Specific Antigen (PSA test)—one annually for men age 40 and older 	<p>PPO: \$25 copayment (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Routine pap test <p>Note: We cover the office visit if it is on the same day as the pap test. See <i>Diagnostic and treatment services</i> in this Section.</p>	<p>PPO: Nothing for first \$35 in charges (No deductible), then 15% of the Plan allowance</p> <p>Non-PPO: Nothing for first \$35 in charges (No deductible), then 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Routine mammogram—for women age 35 and older, as follows: <ul style="list-style-type: none"> — Ages 35 through 39, one during this five year period — Ages 40 through 64, one every calendar year — Age 65 and older, one every two consecutive calendar years 	<p>PPO: \$25 copayment (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster—one every 10 years, age 19 and older (except as provided for under <i>Preventive care, children</i>) • Influenza/Pneumococcal vaccines, one annually, age 65 and older 	<p>PPO: \$5 copayment (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>

Preventive care, children	You pay
<p>Childhood immunizations, ages 3 through 21, limited to:</p> <ul style="list-style-type: none"> • Immunizations recommended by the American Academy of Pediatrics • Meningococcal immunization—lifetime limit of two vaccinations 	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: The difference, if any, between our allowance and the billed amount (No deductible)</p>
<ul style="list-style-type: none"> • Well-child care—routine examinations and immunizations, through age 2 <p>Note: For the coverage of the initial newborn exam see <i>Diagnostic and treatment services</i> in this Section.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: The difference, if any, between our allowance and the billed amount (No deductible)</p>
<ul style="list-style-type: none"> • Examinations, limited to: <ul style="list-style-type: none"> — 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 	<p>PPO: \$20 copayment (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care • Amniocentesis 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Group B streptococcus infection screening • Sonograms • Fetal monitoring • Other tests medically indicated for the unborn child <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see Section 3. <i>How to get approval for...</i> for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you, your representative, your physician, or your hospital must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Section 5(c). <i>Inpatient hospital</i> and Section 5(b). <i>Surgical procedures</i>. 	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges</i></p>

Family planning	You pay
Voluntary family planning services, limited to: <ul style="list-style-type: none"> • Voluntary sterilization • Implanted contraceptives (such as Norplant) • Intrauterine devices (IUDs) 	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
<ul style="list-style-type: none"> • Injectable contraceptive drugs (such as Depo provera) • Diaphragms Note: We cover oral contraceptives only under the Prescription drug benefit. See Section 5(f). <i>Prescription drug benefits.</i>	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
<i>Not covered: Reversal of voluntary surgical sterilization, genetic counseling</i>	<i>All charges</i>
Infertility services	
Diagnosis and treatment of infertility, except as shown in <i>Not covered</i> . Note: For surgical services see Section 5(b). Note: Prescription drugs for infertility are covered only under the Prescription drug benefit. See Section 5(f). <i>Prescription drug benefits.</i>	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
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Infertility services after voluntary sterilization</i> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> — <i>Artificial insemination</i> — <i>In vitro fertilization</i> — <i>Embryo transfer and gamete intrafallopian tube transfer (GIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges</i>
Allergy care	
<ul style="list-style-type: none"> • Testing • Treatment, except for allergy injections • Allergy serum 	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Allergy injections	PPO: \$5 copayment each (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Provocative food testing and sublingual allergy desensitization</i> • <i>Environmental control units, such as air conditioners, purifiers, humidifiers, and dehumidifiers</i> 	<i>All charges</i>
Treatment therapies	
<ul style="list-style-type: none"> • 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). <i>Organ/tissue transplants.</i> <ul style="list-style-type: none"> • Dialysis—Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy—Home IV and antibiotic therapy • Respiratory and inhalation therapies • Growth hormone therapy (GHT) Note: We cover GHT only when it is preauthorized through our disease management program. Call 1-800-433-NALC (6252) for preauthorization. If you do not preauthorize, we will not cover the GHT or related services and supplies. Note: The growth hormone is covered under the Prescription drug benefit. See Section 5(f). <i>Prescription drug benefits.</i>	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
<i>Not covered: Chelation therapy, except as treatment for acute arsenic, gold, lead or mercury poisoning</i>	<i>All charges</i>

Physical and occupational therapies	You pay
<ul style="list-style-type: none"> A combined total of 50 visits per calendar year for treatment provided by a licensed registered therapist or physician for the following: <ul style="list-style-type: none"> Physical therapy Occupational therapy <p>Therapy is covered when the attending physician:</p> <ul style="list-style-type: none"> 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. <p>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.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Maintenance therapy, including cardiac rehabilitation and exercise programs 	<p><i>All charges</i></p>
Speech therapy	
<ul style="list-style-type: none"> Up to 30 visits per calendar year for treatment provided by a licensed registered speech therapist or physician <p>Therapy is covered when the attending physician:</p> <ul style="list-style-type: none"> 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. 	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<p><i>Not covered: Maintenance therapy</i></p>	<p><i>All charges</i></p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Hearing testing for covered diagnoses, such as otitis media and mastoiditis First hearing aid and examination, limited to services necessitated by accidental injury 	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Routine hearing testing Hearing aid and examination, except when necessitated by accidental injury 	<p><i>All charges</i></p>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Eye examinations for covered diagnoses, such as cataract and glaucoma 	<p>PPO: \$20 copayment per visit (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) <p>Note: For examinations for amblyopia and strabismus, see <i>Preventive care, children</i> in this Section.</p>	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses or contact lenses and examinations for them Eye exercises and orthoptics Radial keratotomy and other refractive surgery Refractions 	<p><i>All charges</i></p>

Foot care	You pay
<p>Nonsurgical routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes</p>	<p>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</p>
<ul style="list-style-type: none"> • 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 	<p>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</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> • <i>Foot orthotics, arch supports, heel pads and cups</i> • <i>Orthopedic and corrective shoes</i> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • 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 <p>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). <i>Inpatient hospital</i>. Insertion of the device is paid as surgery. See Section 5(b). <i>Surgical procedures</i>.</p>	<p>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</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics (shoe inserts)</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacement provided less than 3 years after the last one we covered</i> 	<p><i>All charges</i></p>
Durable medical equipment (DME)	
<p>Durable medical equipment (DME) is equipment and supplies that:</p> <ol style="list-style-type: none"> 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. 	<p>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</p>

Durable medical equipment (DME) – Continued on next page

Durable medical equipment (DME) (continued)	You pay
<p>Note: Call us at 1-800-433-NALC (6252) as soon as your physician prescribes equipment or supplies. We have arranged with a health care provider to rent or sell durable medical equipment at discounted rates and will tell you more about this service when you call.</p> <p>We cover rental or purchase (at our option) including repair and adjustment of durable medical equipment:</p> <ul style="list-style-type: none"> • Oxygen and oxygen apparatus • Dialysis appliances <p>We also cover supplies, such as:</p> <ul style="list-style-type: none"> • Hospital beds • Wheelchairs • Crutches, canes, and walkers • Insulin and diabetic supplies • Needles and syringes for covered injectables • Ostomy and catheter supplies • Home IV and antibiotic therapy 	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>DME replacements provided less than 3 years after the last one we covered</i> • <i>Sun or heat lamps, whirlpool baths, saunas and similar household equipment</i> • <i>Safety, convenience and exercise equipment</i> • <i>Communication equipment including computer “story boards” or “light talkers”</i> • <i>Enhanced vision systems, computer switch boards or environmental control units</i> • <i>Heating pads, air conditioners, purifiers and humidifiers</i> • <i>Stair climbing equipment, stair glides, ramps, elevators</i> • <i>Modifications or alterations to vehicles or households</i> • <i>Other items (such as wigs) that do not meet the criteria 1 thru 6 above</i> 	<p><i>All charges</i></p>
<p>Home health services</p>	
<p>Up to 90 days per calendar year (with a maximum Plan payment of \$75 per day) when:</p> <ul style="list-style-type: none"> • 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. 	<p>PPO: 20% of the Plan allowance (No deductible) plus all charges after we pay \$75 per day</p> <p>Non-PPO: 20% of the Plan allowance (No deductible) plus all charges after we pay \$75 per day</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient’s family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative</i> 	<p><i>All charges</i></p>

Chiropractic	You pay
Coverage limited to medically underserved areas. See Section 3. <i>Covered providers.</i>	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Alternative treatments	
Acupuncture, limited to treatment by a doctor of medicine or osteopathy for pain relief	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
<i>Not covered:</i> • <i>Naturopathic services</i> Note: In medically underserved areas, we may cover services of alternative treatment providers. See Section 3. <i>Covered providers.</i>	<i>All charges</i>
Educational classes and programs	
Coverage is limited to: • Smoking Cessation—One smoking cessation program per member per lifetime, up to a maximum Plan payment of \$100 including all related expenses such as drugs	PPO: Nothing for the first \$100 Non-PPO: Nothing for the first \$100
• Diabetes training for self-management when: — Prescribed by the attending physician; and — Administered by a covered provider, such as a registered nurse.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

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

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

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

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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.	
<p>Surgical procedures</p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 • Gastric bypass or stapling for treatment of morbid obesity—a condition in which an individual weighs 100 pounds or 100% over his or her normal weight with complicating medical conditions and attempts to reduce weight using a doctor-monitored diet and exercise program were unsuccessful; patients must be age 18 or older • Insertion of internal prosthetic devices. See Section 5(a). <i>Orthopedic and prosthetic devices</i>, for device coverage information. 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>

Surgical procedures - Continued on next page

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Voluntary sterilization, surgically implanted contraceptives and intrauterine devices (IUDs) • Debridement of burns <p>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.</p> <p>The Plan allowance for an assistant surgeon will not exceed 25% of our allowance for the surgeon.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our payment and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone) • Cosmetic surgery, except for: repair of accidental injury if repair is initiated within six months after an accident; correction of a congenital anomaly; or breast reconstruction following a mastectomy • Radial keratotomy and other refractive surgery • Procedures performed through the same incision deemed incidental to the total surgery, such as appendectomy, lysis of adhesion, puncture of ovarian cyst • Reversal of voluntary sterilization • Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standby surgeons are medically necessary • Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as listed under Section 5(a). Foot care 	<p><i>All charges</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> — The condition produced a major effect on the member’s appearance; and — The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a congenital anomaly (condition that existed at or from birth and is a significant deviation from the common form or norm). Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> — Surgery to produce a symmetrical appearance on the other breast — Treatment of any physical complications, such as lymphedemas <p>Note: Congenital anomaly does not include conditions related to teeth or intra-oral structures supporting the teeth.</p> <p>Note: We cover internal and external breast prostheses, surgical bras and replacements. See Section 5(a). <i>Orthopedic and prosthetic devices</i>, and Section 5(c). <i>Inpatient hospital</i>.</p> <p>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.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>

Reconstructive surgery – Continued on next page

Reconstructive surgery <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Injections of silicone, collagens and similar substances</i> • <i>Surgeries related to sex transformation or sexual dysfunction</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Treatment of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures 	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> • Bone • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver • Lung: Single—only for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, or emphysema; Double—only for patients with cystic fibrosis • Pancreas • Allogenic bone marrow transplants, limited to patients with acute leukemia, advanced Hodgkin’s lymphoma, advanced non-Hodgkin’s lymphoma, advanced neuroblastoma, aplastic anemia, chronic myelogenous leukemia, infantile malignant osteoporosis, severe combined immunodeficiency, thalassemia major, or Wiskott-Aldrich syndrome • Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support for acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma, advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal retroperitoneal, and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas 	<p>Nothing, for services obtained through the National Transplant Program (NTP). (No deductible)</p> <p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>

Organ/tissue transplants – Continued on next page

Organ/tissue transplants <i>(continued)</i>	You pay
<p>National Transplant Program (NTP)—The Plan participates in The First Health, National Transplant Program. Before your initial evaluation as a potential candidate for a transplant procedure, you or your physician must contact First Health at 1-800-622-6252 and speak to a Transplant Case Manager. You will be given information about this program including a list of participating providers. Charges for services performed by a National Transplant Program provider, whether incurred by the recipient or donor are paid at 100%. Participants in the program must receive prior approval from the Plan for travel and lodging expenses.</p> <p>Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.</p>	<p>Nothing, for services obtained through the National Transplant Program (NTP). (No deductible)</p> <p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p>
<p>Note: Limited Benefits—If you do not obtain prior approval or do not use a designated facility, we pay a maximum of \$100,000 for each listed transplant (kidney limit, \$50,000), for these combined expenses: pre-transplant evaluation; organ procurement; and inpatient hospital, surgical and medical expenses. We pay benefits according to the appropriate benefit section, such as Section 5(c), <i>Inpatient hospital</i>, and <i>Surgical procedures</i>. The limitation applies to expenses incurred by either the recipient or donor.</p> <p>Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute (NCI)- or National Institute of Health (NIH)-approved clinical trial at a designated center for excellence when approved by our medical director in accordance with the Plan’s protocols.</p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • 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 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>PPO: 15% of the Plan allowance (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (No deductible)</p>
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital outpatient department • Ambulatory surgical center • Office • Other outpatient facility 	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount</p> <p>Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for the anesthesia charges.</p>

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The PPO calendar year deductible is \$250 per person (\$500 per family). If you use non-PPO providers, your calendar year deductible is \$300 per person (\$600 per family). Whether you use PPO or non-PPO providers, your deductible will not exceed \$300 per person (\$600 per family). Unlike Sections (a) and (b), in this Section, the calendar year deductible applies to only a few benefits. In that case, we say “(calendar year deductible applies)”.
- Be sure to read Section 4. *Your costs for covered services*, for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage*.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Please keep in mind that when you use a PPO hospital, the professionals who provide services to you in the hospital, such as emergency room physicians, radiologists, anesthesiologists, and pathologists, may **not** all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.
- The amounts listed below are for charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Look in 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.

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Benefit Description	You pay
NOTE: The calendar year deductible applies ONLY when we say “(calendar year deductible applies)”.	
Inpatient hospital	
Room and board, such as: <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>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.</p> <p>Note: When the non-PPO hospital bills a flat rate, we prorate the charge as follows: 30% room and board and 70% other charges.</p>	PPO: 10% of the Plan allowance Non-PPO: \$100 copayment per admission and 30% of the Plan allowance

Inpatient hospital – Continued on next page

Inpatient hospital <i>(continued)</i>	You pay
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Preadmission testing (within 7 days of admission) • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Internal prostheses • Professional ambulance service to the nearest hospital equipped to handle your condition • Occupational, physical, and speech therapy <p>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 (<i>Inpatient hospital</i>) and when the anesthesiologist bills, we pay anesthesia benefits. See Section 5(b). <i>Surgical procedures</i>.</p> <p>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.</p> <p>Note: We cover your admission for inpatient foot treatment even if no other benefits are payable.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: \$100 copayment per admission and 30% of the Plan allowance</p>
<p>Take-home items</p> <ul style="list-style-type: none"> • Medical supplies, appliances, and equipment; and any covered items billed by a hospital for use at home 	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 30% of the Plan allowance (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Any part of a hospital admission that is not medically necessary (See Section 10. Definitions . . . Medical Necessity), such as long term care or when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting.</i> • <i>Custodial care; see Section 10. Definitions . . . Custodial care</i> • <i>Non-covered facilities, such as nursing homes, extended care facilities, and schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<p><i>All charges</i></p>

Outpatient hospital or ambulatory surgical center	You pay
<p>Services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, casts, splints, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental physical impairment. We do not cover the dental procedures.</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)</p>
<p><i>Not covered: Personal comfort items</i></p>	<p><i>All charges</i></p>
Skilled nursing care facility benefits	
<p>Limited to care in a skilled nursing facility (SNF) when your Medicare Part A is primary. We cover semiprivate room, board, services and supplies in a SNF for up to 30 days per confinement when:</p> <ul style="list-style-type: none"> • You are admitted directly from a hospital stay of at least 3 consecutive days; • You are admitted for the same condition as the hospital stay; • Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and • SNF care is medically necessary. 	<p>PPO: Nothing</p> <p>Non-PPO: The difference, if any, between our allowance and the billed amount</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All charges</i></p>
Hospice care	
<p>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.</p> <p>Limited benefits: We pay up to \$3000 per lifetime for a combination of inpatient and outpatient services.</p>	<p>PPO: 15% of the Plan allowance, and all charges after we pay \$3000 (calendar year deductible applies)</p> <p>Non-PPO: 30% of the Plan allowance, and all charges after we pay \$3000 (calendar year deductible applies)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Private nursing care</i> • <i>Homemaker services</i> • <i>Bereavement services</i> 	<p><i>All charges</i></p>
Ambulance	
<p>Local professional ambulance service when medically necessary</p>	<p>PPO: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)</p>
<p><i>Not covered: Transportation (other than professional ambulance services), such as by ambulance or medicab</i></p>	<p><i>All charges</i></p>

Section 5(d). Emergency services/accidents

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

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

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What is an accidental injury?

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

Benefit Description	You pay After the calendar year deductible...
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.	
Accidental injury	
<p>If you receive the care within 72 hours after your accidental injury, we cover:</p> <ul style="list-style-type: none"> • Nonsurgical services and supplies by a physician • Related nonsurgical outpatient hospital services and supplies • Local professional ambulance service when medically necessary <p>Note: For surgery related to an accidental injury, see Section 5(b). <i>Surgical procedures</i>.</p>	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: The difference, if any, between the Plan allowance and the billed amount (No deductible)</p>
<p>If you receive care for your accidental injury after 72 hours, we cover:</p> <ul style="list-style-type: none"> • Outpatient hospital and physician services and supplies not related to surgical procedures 	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between the Plan allowance and the billed amount</p>

Medical emergency	You pay
<p>Outpatient medical services and supplies. See Section 5(a). <i>Medical services and supplies...</i></p>	<p>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</p>
<p>Surgical services. See Section 5(b) <i>Surgical procedures.</i></p>	<p>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</p>
Ambulance	
<p>Local professional ambulance service when medically necessary, not related to an accidental injury</p>	<p>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</p>
<p><i>Not covered: Transportation (other than professional ambulance services), such as by ambulance or medicab</i></p>	<p><i>All charges</i></p>

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

In-Network Benefits

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- There is a separate calendar year deductible for In-Network mental health and substance abuse of \$250 per person (\$500 per family). This calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” to show when the calendar year deductible does not apply.
- When no In-Network provider is available, Out-of-Network benefits will be paid.
- Be sure to read Section 4. *Your costs for covered services*, for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage*.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 33.

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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	
<p>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.</p> <p>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.</p>	<p>Your cost-sharing responsibilities are no greater than for other illness or conditions, such as \$20 copayment per office visit, or 15% of the Plan allowance for other outpatient services after the calendar year deductible is met.</p>
<ul style="list-style-type: none"> • Outpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Outpatient medication management 	\$20 copayment per visit (No deductible)
<ul style="list-style-type: none"> • Outpatient diagnostic tests 	15% of the Plan allowance

In-Network benefits — Continued on next page.

In-Network benefits <i>(continued)</i>	You pay
<ul style="list-style-type: none"> Inpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers 	15% of the Plan allowance
<ul style="list-style-type: none"> Inpatient services provided by a hospital or other facility Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	Nothing (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Services we have not approved</i> <i>Treatment for learning disabilities and mental retardation</i> <i>Treatment for marital discord</i> <p>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.</p> <p>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.</p>	<i>All charges</i>

Preauthorization

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

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

- Exceptions**

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

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

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

Where to file claims

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

United Behavioral Health
P.O. Box 23250
Oakland, CA 94623-0250
Questions? 1-877-468-1016

Out-of-Network Benefits

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

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

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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: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Ward or semiprivate accommodations • Other charges 	\$300 treatment facility calendar year deductible, then 50% of the Plan allowance; all charges after 30 days
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Services by pastoral, marital, drug/alcohol, and other counselors</i> • <i>Treatment for learning disabilities and mental retardation</i> • <i>Treatment for marital discord</i> • <i>Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staffs</i> <p>Note: In medically underserved areas, we may cover services of pastoral counselors. See Section 3. <i>Covered providers</i>.</p>	<i>All charges</i>
Lifetime maximum	Out-of-Network inpatient care for the treatment of substance abuse in a treatment facility is limited to a 30-day lifetime benefit.
Precertification	The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive these Out-of-Network benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See Section 3 for details.
Where to file claims	United Behavioral Health P.O. Box 23250 Oakland, CA 94623-0250 Questions? 1-877-468-1016

Section 5(f). Prescription drug benefits

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

- We cover prescribed medications and supplies as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year drug deductible of \$25 per person or \$50 per family applies only to non-network benefits. We say “(No deductible)” to show when the calendar year drug deductible does not apply.
- Some drugs require prior authorization. Call the Plan at 1-800-433-NALC (6252) for information.
- Maximum dosage dispensed may be limited by protocols established by the Plan.
- When we say “Medicare” in this Section we mean you have Medicare Part B and it is primary.
- Be sure to read Section 4. *Your costs for covered services*, for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9. *Coordinating benefits with other coverage*.

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy.
- **Network pharmacy**—Present your Plan identification card at an NALC CareSelect Network pharmacy to purchase prescription drugs. Call 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 with your order. Send this form, along with your prescription(s) and payment, in the preaddressed envelope to:

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

- **We use an open formulary.** If your physician believes a name brand product is necessary, or there is no generic available, your physician may prescribe a name brand drug from our formulary list. These preferred name brand drugs are selected to meet patient needs at lower cost. To order the Formulary pamphlet, call 1-800-933-NALC (6252).
- **These are the dispensing limitations.**
 - Network retail pharmacy—You may obtain up to a 30-day supply plus one refill for each prescription. No deductible applies. After one refill, you must obtain a new prescription and submit it to the mail order program. Failure to do so results in benefits payable at the non-network retail pharmacy benefit level (which includes a deductible), and you will need to file a claim for reimbursement.
 - Non-network retail pharmacy—You may obtain up to a 30-day supply and unlimited refills for each prescription. You will need to file a claim for reimbursement.
 - Mail order—You may order up to a 60-day or 90-day (21-day minimum) supply of medication for each prescription or refill. No deductible applies. You cannot obtain a refill until 75% of the drug has been used. Medications dispensed through the mail order program are subject to the following standards: the professional judgment of the pharmacist, limitations imposed on controlled substances, manufacturer’s recommendations, and applicable state law.
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- Why use generic drugs? Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you—and us—less than a name brand prescription.

Benefit Description begins on next page.

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

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

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

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

Benefit Description	You pay After the calendar year deductible...
<p>NOTE: The calendar year drug deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Covered medications and supplies	
<p>Each new enrollee receives a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope. You may purchase the following medications and supplies from a pharmacy or by mail:</p> <ul style="list-style-type: none"> • 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 <i>Not covered</i> • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Drugs for sexual dysfunction (only when the dysfunction is caused by medically documented organic disease and prior authorization has been given) 	<p>Retail:</p> <ul style="list-style-type: none"> • Network retail: 25% of cost (No deductible) • Network retail Medicare: 15% of cost (No deductible) • Non-network retail: 40% of the Plan allowance, and the difference, if any, between our allowance and the billed amount • Non-network retail Medicare: 40% of the Plan allowance, and the difference, if any, between our allowance and the billed amount (No deductible) <p>Mail order:</p> <ul style="list-style-type: none"> • 60-day supply: \$8 generic/\$17 name brand (No deductible) • 90-day supply: \$12 generic/\$25 name brand (No deductible) <p>Mail order Medicare:</p> <ul style="list-style-type: none"> • 60-day supply: \$5 generic/\$13 name brand (No deductible) • 90-day supply: \$7.50 generic/\$19.50 name brand (No deductible) <p>Note: If there is no generic equivalent available, you will have to pay the name brand copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies when prescribed for cosmetic purposes</i> • <i>Vitamins, nutrients and food supplements, even when a physician prescribes or administers them</i> • <i>Over-the-counter medicines and supplies</i> 	<p><i>All Charges</i></p>

Section 5(g). Special features

Special features	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24-hour nurse line	You may call a registered nurse at 1-800-622-NALC (6252) 24 hours a day, 7 days a week, to discuss your health concerns and treatment options.
24-hour help line for mental health and substance abuse	You may call 1-877-468-1016, 24 hours a day, 7 days a week, to access in-person support for a wide range of concerns, including depression, eating disorders, coping with grief and loss, alcohol or drug dependency, physical abuse and managing stress.
Services for deaf and hearing impaired	<p>TDD lines are available for the following:</p> <p>CAREMARK: 1-800-238-1217 (prescription benefit information)</p> <p>First Health: 1-800-259-8179 (PPO locator, 24-hour nurse line, medical inpatient hospital precertification, National Transplant Program)</p> <p>United Behavioral Health: 1-800-842-2479 (mental health and substance abuse information)</p>
Centers of excellence for transplants/heart surgery	The Plan participates in the First Health National Transplant Program that includes more than 25 centers of excellence. Call 1-800-622-6252 for information.
Disease management programs	These programs offer a considerable amount of personalized attention from clinicians and program educators. Nurse educators are available to discuss lifestyle changes, therapeutic outcomes, and other health related matters to assist patients in dealing with their experiences. Support is available for patients with multiple sclerosis, growth hormone deficiency, hemophilia, hepatitis, diabetes, and other diseases. You may be contacted about one of these programs.
Discounts for durable medical equipment (DME)	We have arranged with a health care provider to rent or sell durable medical equipment at discounted rates. Call us at 1-800-433-NALC (6252).
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. <i>Overseas claims.</i>

Section 5(h). Dental benefits

We have no dental benefit.

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

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

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

Hospital Plus (hospital indemnity)

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

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

Hospital Plus allows you to choose the amount of coverage you need. You may elect to receive a \$75 a day, \$50 a day or \$30 a day plan. Members can insure their spouses and eligible children also. The spousal coverage is the same as the member's. Children's coverages are limited to either \$45 a day, \$30 a day or \$18 a day plans. Benefits will be based on the number of days in the hospital, up to 365 days or as much as \$27,375 (if a \$75 a day benefit is chosen).

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

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

For more information, please call the United States Letter Carriers Mutual Benefit Association at 202/638-4318 Monday through Friday or 1-800-424-5184 Tuesdays and Thursdays, 8:00 a.m. - 3:30 p.m. Eastern time.

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

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

How to claim benefits

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

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

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

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

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

In addition:

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

Records

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

Deadline for filing your claim

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

Overseas claims

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

When we need more information

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

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

Section 8. The disputed claims process

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

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

- Write to us within 6 months from the date of our decision;
- Send your request to us at: NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149-0001;
- Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits forms.

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

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

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

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

We will write to you with our decision.

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

You must write to OPM within:

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

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

Send OPM the following information:

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

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must 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.

continues on next page

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

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

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

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

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

- a) We haven't responded to your initial request for care or preauthorization/prior approval, then call us at 703/729-4677 or 1-888-636-NALC (6252) and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they too can expedite your request, or
 - You can call OPM's Health Benefits Contracts Division 2 at 202/606-3818 between 8 a.m. and 5 p.m. Eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has two parts:

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

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

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

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

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

Claims process: If Medicare is primary, you probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 703/729-4677 or 1-888-636-NALC (6252).

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

- If you have Medicare Part A as primary payer, we waive:
 - The copayment for a hospital admission
 - The coinsurance for a hospital admission
 - The deductible for inpatient care in a treatment facility
- If you have Medicare Part B as primary payer, we waive:
 - The PPO copayments for office or outpatient visits
 - The PPO copayments for preventive care
 - The PPO copayments for allergy care
 - The coinsurance for services billed by physicians, other health care professionals, and facilities
 - All calendar year deductibles

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

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

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

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

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

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

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

- **Private contract with your physician**

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

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

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

TRICARE

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

Workers’ Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

Section 10. Definitions of terms we use in this brochure

Admission	The period from entry (admission) into a hospital or other covered facility until discharge. In counting days of inpatient care, the date of entry and the date of discharge are counted as a single day.
Assignment	Your authorization for us to issue payment of benefits directly to the provider. We reserve the right to pay you directly for all covered services.
Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See Section 4. <i>Your costs for covered services.</i>
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. <i>Your costs for covered services.</i>
Cosmetic surgery	Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.
Covered services	Services we provide benefits for, as described in this brochure.
Custodial care	<p>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 includes such services as:</p> <ul style="list-style-type: none">• 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. <p>The Plan determines whether services are custodial care.</p>
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. <i>Your costs for covered services.</i>
Effective date	<p>The effective date of benefits described in this brochure is:</p> <ul style="list-style-type: none">• January 1 for continuing enrollments and for all annuitant enrollments;• The first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during the Open Season; or• Determined by the employing office or retirement system for enrollments and changes that are not Open Season actions.
Experimental or investigational services	<p>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.</p> <p>A medical treatment or procedure, or a drug, device, or biological product is considered experimental or investigational if reliable evidence shows that:</p> <ul style="list-style-type: none">• 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. <p>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.</p>

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.

PPO benefits:

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

Non-PPO benefits:

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

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

Out-of-Network mental health and substance abuse benefits:

Our allowance is based on the 80th percentile of data gathered by Ingenix, Inc., for physician and other professional services when you:

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

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

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

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

Us/We Us and we refer to the NALC Health Benefit Plan.

You You refers to the enrollee and each covered family member.

Section 11. FEHB facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Where you can get information about enrolling in the FEHB Program**

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

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

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

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

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

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

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.
- **When benefits and premiums start**

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

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

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

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

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

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

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

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

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

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

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

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

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

continues on next page

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

- **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *Long term care insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the elderly. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planning.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed \$50,000. Home care for only three 8- hour shifts a week can exceed \$20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Department of Defense/FEHB Demonstration Project

What is it?

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

Who is eligible

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

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

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

The demonstration areas

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

When you can join

You may enroll under the DoD/FEHB Demonstration Project during the 2001 Open Season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions, and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during open season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including “The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project,” on the OPM web site at www.opm.gov.

Temporary Continuation of Coverage (TCC) eligibility

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

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

Other features

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

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

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2002 Rate Information for NALC Health Benefit Plan

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	321	\$97.86	\$45.87	\$212.03	\$99.39	\$115.52	\$28.21
High Option Self and Family	322	\$223.41	\$83.72	\$484.06	\$181.39	\$263.75	\$43.38

Save Your Life!

Click here for the Five Steps to Safer Health Care

Search:

[Download a FEHB Guide](#)

[Premium Conversion](#)

[Reporting Fraud](#)

[Disputed Claims](#)

[Patient Bill of Rights](#)

[Mental Health & Substance Abuse Parity](#)

[DoD Demo Project](#)

2002 Carrier Call Letter

Nearly 65?

IMPORTANT REMINDER

Whether you are retired or still employed, if you are not already receiving Social Security benefits you must begin the process of signing up for Medicare Part A three months before your 65th birthday (you can delay

You are here: [OPM Home](#) > [Insurance](#) > [FEHB Home](#)

U. S. Office of Personnel Management

Federal Employees Health Benefits Program

Providing health insurance benefits to 9 million Federal enrollees and dependents.



[New Federal Employee? Click Here](#)

[Program Overview](#) | [Frequently Asked Questions](#) | [Glossary](#)



NEW FEHB Plan **NEW** Changes and Premium Rates for 2002 Announced

- [News Release](#)
- [Plan Changes](#)
- [Plan Rates](#)

NEW TRICARE & **NEW** Medicare/Medicaid Conversions

Regulations were issued September 26 for conversions between FEHB and DoD's TRICARE program or Medicare/Medicaid and certain other government sponsored health plans.

RIGHTS OF RESERVISTS CALLED TO ACTIVE DUTY

Guidance has been issued on the rights and benefits of Federal employee reservists who are called to active duty — see [Compensation Memo 2001-09 of September 14, 2001](#). FEHB coverage is discussed in item 7 of Attachment 1 to that letter.

The next Open Season will be held November 12 through December 10, 2001.



[FEHB Law](#)

[FEHB](#)

[Regulations](#)

[FEHB](#)

[Handbook](#)

[FEHB Facts](#)

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[for Former](#)

[Spouses](#)

[FEHB and](#)

[Medicare](#)

[Temporary](#)

[Continuation of](#)

[Coverage \(RI](#)

[79-27, 12/00\)](#)

[the start of Part B](#)).

Send questions on the FEHB program to fehb@opm.gov.

Send comments on these pages to insure-webmaster@opm.gov.

Open Season Plan Information Pages

In November of each year we post the guides, plan brochures, and other files used to choose a FEHB plan for the following year. These files are available for 1997 through this year.

To plan information for:

[2001](#) | [2000](#) | [1999](#) | [1998](#) | [1997](#)

Choosing a Plan

- [Considerations in Selecting a Plan](#)
- [Considering Dental Benefits FAQ](#)
- [Changing Plans FAQ](#)

Enrolling in a Plan

- [When Can I Enroll, Change Plans, or Drop My Enrollment?](#)
- [How to Enroll](#)
- [Election Form \(SF 2809\)](#)

FEHB and Medicare

- [FEHB and Medicare Booklet](#)
- [Medicare Web Site](#)

Quality Care is Vital to Your Health

- [Satisfaction Surveys and Accreditation](#)
- [Your Guide to Choosing Quality Health Care](#)
- [PlanSmartChoice](#) can help you to identify the health plan that is right for you.
- [Health Plan Report Card](#) An interactive tool that gives quality information on FEHB managed care plans.

Getting the Most from Your Plan

- [Getting the Most Benefits](#)
- [Prescription Drugs FAQ](#)

Continuation of Coverage

- [Temporary Continuation of Coverage](#)
- [TCC and HIPAA](#)
- [Former Spouses](#)
- [Retirees and Survivor Annuity](#)

[Information for Agency Human Resources Personnel](#)

Is there a local HMO that you would like to join but can't because they don't participate in the FEHB program? Ask them to consider joining the program, and tell them to take a look at <http://www.opm.gov/insure/carriers/index.htm>.

[Insurance Programs Home](#) | [Life Insurance](#) | [Long Term Care Insurance](#) | [Retirement](#) |
[OPM Web Privacy Policy](#) | [OPM Web Site Index](#) | [OPM Home Page](#)



Page updated 26 September 2001



UNIFORMED SERVICES RETIREES'

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

DEMONSTRATION

1 October 2001 -- The Office of Personnel Management has issued an interim rule to allow TRICARE-eligible FEHB Program annuitants and former spouses to suspend their FEHB enrollments, and then return to the FEHB Program during an Open Season, or return to FEHB coverage immediately if they involuntarily lose TRICARE coverage. The [Interim Final Rule](#) was published in the Federal Register on September 27, 2001.

DoD/FEHBP Demonstration Project Call Center

1-877-DOD-FEHB (1-877-363-3342)
Hours of Operation: 7:00 AM - 7:00 PM Central Standard Time (CST), Monday - Friday

Related Links

- [The Uniform Services Federal Employees Health Benefits Program Demonstration Project](#)
- [Federal Employees Health Benefits Test Program for Military Retirees, Families Begins](#)
- [DoD/FEHBP Demonstration Program May Be for You!](#)
- [Uniformed Services Retirees' Federal Employees Health Benefits Program Test Sites Selected](#)
- [OPM Federal Employees Health Benefits](#)
- [Frequently Asked Questions](#)
- [Fact Sheet \(PDF\)](#)
- [FEHBP Tri-fold](#)

Selected Sites

Dover Air Force Base, Delaware	
ZIP Codes	Map
Commonwealth of Puerto Rico	
ZIP Codes	Map
Fort Knox, Kentucky	
ZIP Codes	Map
Greensboro/Winston-Salem/High Point, North Carolina	
ZIP Codes	Map
Dallas, Texas	
ZIP Codes	Map
Humboldt County, California area	
ZIP Codes	Map
Naval Hospital, Camp Pendleton, California	
ZIP Codes	Map
New Orleans, Louisiana	
ZIP Codes	Map
Coffee, Georgia (includes parts of Florida, Georgia, and South Carolina)	
ZIP Codes	Map
Adair, Iowa [includes all of Iowa (except for zip codes in Offutt AFB's catchment area) and parts of Minnesota, South Dakota, Nebraska, Kansas, and Missouri]	
ZIP Codes	Map

Bulletin	Invitation	Postcard
• Bulletin	• Adair County	• Postcard 1
• Adair County	• Camp Pendleton	• Postcard 2
• Camp Pendleton	• Coffee County	• Spanish Version
• Coffee County	• Dallas	• Spanish
• Dallas	• Dover	
• Dover	• Fort Knox	
• Fort Knox	• Humboldt	
• Humboldt	• New Orleans	
• New Orleans	• Puerto Rico	
• Puerto Rico	• Winston Salem	
• Winston Salem		
• Spanish Version		

- [Bulletin](#)

Spanish Version

- [Programa de Beneficios de Salud para Empleados Federales](#)
 - [Preguntas Mas Frecuentes](#)
 - [Proyecto de Demostración del Programa de Beneficios de Salud para Empleados Federales](#)
 - [FEHBP Spanish handbook](#)
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THE DOD/FEHBP DEMONSTRATION PROJECT MAY BE FOR YOU!

With the conclusion of the education sessions for Open Season 2001, 17,519 people attended one of the 90 education sessions that were held throughout the ten demonstration sites. Open Season is currently under way with only a few days left to enroll. If you have any questions, please call the DoD Customer Care Center at 1-877-DOD-FEHB (1-877-363-3342).

TRICARE's Iron Man, FEHBP Program Manager Duaine Goodno, recently wrapped up a demanding travel schedule in which he visited places far and wide to educate eligible TRICARE beneficiaries about the ongoing and expanded FEHBP demo. His education series drew large crowds even in out-of-the-way places. In just over 2 months, Duaine traveled to 54 sites, conducted 88 meetings and spoke to over 17,500 people. Sometimes he spoke to 5 crowds in a day! Now that Duaine is back from the FEHBP education series, he says he'll take up something easy - - like triathlons! Duaine's hard work is appreciated by beneficiaries and TRICARE leadership alike. Thanks Duaine!"

- [Frequently Asked Questions about the DoD/FEHB Demonstration Project and Medicare](#)

*The [Military Health System Web Site](#) is the Official Web Presence of the Office of the Assistant Secretary of Defense(Health Affairs) and the TRICARE Management Activity.
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The content of this page was updated on 1 October 2001.
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