

NALC Health Benefit Plan

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



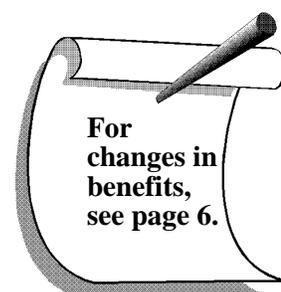
2007

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

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

Who may enroll in this Plan:

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



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

To become a member:

- If you are a Postal Service employee, you must be a dues-paying member of an NALC local branch.
- If you are a non-postal employee, annuitant, survivor annuitant, or a Spouse Equity or TCC enrollee, you become an associate member of NALC when you enroll in the NALC Health Benefit Plan. See page 52 for more details.

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

Enrollment codes for this Plan:

321 Self Only
322 Self and Family



Joint Commission
on Accreditation of Healthcare Organizations



ACCREDITED
202.216.9010 ♦ www.urac.org



JCAHO accreditation: Caremark's 18 Specialty pharmacies and United Behavioral Health

URAC accreditation: Coventry Care Support Program and United Behavioral Health

NCQA accreditation: Caremark's 5 CarePatterns® Disease Management Programs

See the 2007 Guide for more information on ac Authorized for distribution by the:



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

**Important Notice from NALC Health Benefit Plan About
Our Prescription Drug Coverage and Medicare**

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

Visit www.medicare.gov for personalized help,

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

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Introduction

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

NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

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

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Do not ask your physician to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 703-729-4677 or 1-888-636-NALC (6252) and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child age 22 or older (unless he/she is disabled and incapable of self support).
 - If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.

You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Exactly what will you be doing?

About how long will it take?

What will happen after surgery?

How can I expect to feel during recovery?

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

Visit these Web sites for more information about patient safety.

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

Section 1 Facts about this fee-for-service plan

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

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

General features of our Plan

We have a Preferred Provider Organization (PPO):

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are “preferred providers”. When you use our PPO providers, you will receive covered services at reduced cost. Coventry Health Care is solely responsible for the selection of PPO providers in your area. Call 1-800-622-6252 for the names of PPO providers or call us at 703-729-4677 or 1-888-636-NALC (6252) to request a PPO directory. We recommend that you call the PPO provider you select before each visit and verify they continue to participate in the Coventry Health Care network. You can also go to our Web page, which you can reach through the FEHB Web site, www.opm.gov/insure.

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

How we pay providers

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

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

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

Your rights

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

- The NALC Health Benefit Plan has been part of the FEHB Program since July 1960.
- We are a not-for-profit health plan sponsored and administered by the National Association of Letter Carriers (NALC), AFL-CIO.
- Our preferred provider organization (PPO) is Coventry Health Care (formerly 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 and specialty pharmacy services are through CAREMARK.

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

Your medical and claims records are confidential

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

Section 2 How we change for 2007

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

- Texas has been added to the list of medically underserved areas for 2007; Alaska has been removed from the list. (See page 13)

Changes to this Plan

- Your share of the NALC Postal premium will increase by 2.2% for Self Only or 3.0% for Self and Family.
- Your share of the non-Postal premium will increase by 2.1% for Self Only or 2.4% for Self and Family.
- Your coinsurance expenses for inpatient services billed by PPO hospital facilities will never exceed \$2000. Previously, these charges were subject to the \$4000 per person or family catastrophic out-of-pocket maximum. (See page 19)
- Your Network mental health and substance abuse catastrophic out-of-pocket maximum is \$4000. Previously, these charges were subject to the \$3000 per person or family catastrophic out-of-pocket maximum. (See page 19)
- Your coinsurance expenses for mental health and substance abuse inpatient services billed by network hospitals or other facilities will never exceed \$2000. Previously, these charges were subject to the \$3000 per person or family catastrophic out-of-pocket maximum. (See page 19)
- We now cover one tetanus-diphtheria, pertussis (Tdap) booster, age 19 through 64. This is a new benefit for 2007. (See page 26)
- We now cover varicella (chickenpox) vaccine for adults age 19 through 49. This is a new benefit for 2007. (See page 26)
- We now cover routine physical exams for adults age 22 or older. Your copayment is \$20 per visit when you use a PPO provider. Previously, you paid all charges. (See page 27)
- You now pay nothing for maternity (obstetrical) care, including facility care, related to delivery of a newborn, when you use a PPO provider. Previously, you paid 10%. (See pages 28 and 43)
- We now cover spinal manipulations and x-rays under the chiropractic benefit. Previously, you paid all charges for services rendered outside of a medically underserved area. (See page 34)
- We added an NALC Preferred Network of pharmacies that offers higher savings for your short-term prescriptions. This is a new benefit for 2007. (See page 54)
- We now offer the CaremarkDirect Program where you can purchase certain non-covered prescriptions and over-the-counter drugs through the Caremark mail service pharmacy. This is a new benefit for 2007. (See page 57)
- We now offer Enhanced Eldercare Services, a program that offers free assistance for members or their spouses who are caring for an elderly relative or disabled dependent. This is a new benefit for 2007. (See page 56)

Clarifications

- We included diabetic retinopathy in our examples of covered diagnoses for eye examinations. (See page 31)
- We clarified under not covered that DME replacement includes rental charges. (See page 33)
- We updated the criteria for coverage of bariatric surgeries. (See page 36)
- We clarified how we pay skilled nursing facility benefits once Medicare benefits are exhausted. (See page 46)
- We clarified under General exclusions that drugs and supplies are not covered when furnished by a household member or immediate relative. (See page 61)

Section 3 How you get care

Identification cards

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

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

Where you get covered care

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

• Covered providers

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

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

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

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are “medically underserved.” For 2007, the states are Alabama, Arizona, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, West Virginia, and Wyoming.

• Covered facilities

Covered facilities include:

- **Birth center:** A freestanding facility that provides comprehensive maternity care in a home-like atmosphere and is licensed or certified by the jurisdiction.
- **Freestanding ambulatory facility:** An outpatient facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or that has Medicare certification.
- **Hospice:** A facility that 1) provides care to the terminally ill; 2) is licensed or certified by the jurisdiction in which it operates; 3) is supervised by a staff of physicians (M.D. or D.O.) with at least one such physician on call 24 hours a day; 4) provides 24-hour-a-day nursing services under the direction of a registered nurse (R. N.) and has a full-time administrator; and 5) provides an ongoing quality assurance program.

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

The term “hospital” does not include a convalescent home or extended care facility, or any institution or part thereof which a) is used principally as a convalescent facility, nursing home, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operated as a school or residential treatment facility (except as listed in Section 5(e) *Mental health and substance abuse—In-Network Benefits*).

- **Skilled nursing facility (SNF):** A facility eligible for Medicare payment, or a government facility not covered by Medicare, that provides continuous non-custodial inpatient skilled nursing care by a medical staff for post-hospital patients.
- **Treatment facility:** A freestanding facility accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for treatment of substance abuse.

What you must do to get covered care

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

- **Transitional care**

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

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

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

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

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

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

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

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

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

How to get approval for...

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

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted us.
- **Warning:** We will reduce our benefits for the inpatient hospital stay by \$500 if no one contacts us for precertification. In addition, if we determine the stay is not medically necessary, we will not pay any inpatient hospital benefits.
- **How to precertify an admission**
 - You, your representative, your physician, or your hospital must call us at 1-800-622-6252 prior to admission, unless your admission is related to a mental health and substance abuse condition. In that case, call 1-877-468-1016.
 - If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
 - Provide the following information:
 - Enrollee's name and Member identification number;
 - Patient's name, birth date, and phone number;
 - Reason for hospitalization, and proposed treatment, or surgery;
 - Name and phone number of admitting physician;
 - Name of hospital or facility; and
 - Number of planned days of confinement.
 - We will then tell the physician and/or hospital the number of approved inpatient days and send written confirmation of our decision to you, your physician, and the hospital.
- **Maternity care** You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us within two business days for precertification of additional days for your baby.
- **If your hospital stay needs to be extended:** If your hospital stay--including for maternity care--needs to be extended, you, your representative, your physician, or the hospital must ask us to approve the additional days.
- **What happens when you do not follow the precertification rules** If no one contacted us, we will decide whether the hospital stay was medically necessary.
 - If we determine that the stay was medically necessary, we will pay the inpatient charges, but reduce benefits by \$500.
 - If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will pay only for covered medical supplies and services that are otherwise payable on an outpatient basis.

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

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

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

• **Exceptions :**

You do not need precertification in these cases:

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

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

• **Other services**

Other services require precertification, preauthorization, or prior approval.

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

• **Exceptions:**

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

Section 4 Your costs for covered services

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

Copayments

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

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

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

Deductible

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

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

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

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

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

Coinsurance

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

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

If your provider routinely waives your cost

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

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

Waivers

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

Differences between our allowance and the bill

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

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

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your copayment, deductible, and coinsurance. Here is an example about coinsurance: You see a PPO physician who charges \$150, but our allowance is \$100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 15% of our \$100 allowance (\$15). Because of the agreement, your PPO physician will not bill you for the \$50 difference between our allowance and his/her bill.
- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your copayment, deductible, and coinsurance, **plus** any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges \$150 and our allowance is again \$100. Because you’ve met your deductible, you are responsible for your coinsurance, so you pay 30% of our \$100 allowance (\$30). Plus, because there is no agreement between the non-PPO physician and us, he/she can bill you for the \$50 difference between our allowance and his/her bill.

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

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

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

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

- \$4000 per person or family for services of PPO providers/facilities. Your coinsurance expenses for inpatient services billed by PPO hospital facilities will never exceed \$2000.
- \$6000 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:

- \$4000 per person or family for services of network mental health and substance abuse providers/facilities. Your coinsurance expenses for inpatient services billed by network hospitals or other facilities will never exceed \$2000.
- \$8000 per person for out-of-network mental health and substance abuse inpatient hospital treatment (to a maximum of 50 days).

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

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

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

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

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

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

Carryover

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

If we overpay you

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

When Government facilities bill us

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

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

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those 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. You and the FEHB benefit from these payment limits. Outpatient hospital care is not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you...

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

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount—the “equivalent Medicare amount”—set by Medicare’s rules for what Medicare would pay, not on the actual charge;
- you are responsible for your applicable deductibles, coinsurance, or copayments you owe under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) statement 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—whether the physician participates in our PPO network or not,	your deductibles, coinsurance, and copayments.
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

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

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

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

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

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

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

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

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

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

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

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

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

When you have Medicare prescription drug coverage (Part D)

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

When the drug is not covered by Medicare Part D, our benefits are subject to the definitions, limitations, and exclusions in this brochure.

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

Benefits

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

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Overview

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You Pay After calendar year deductible
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Diagnostic and treatment services	
Professional services of physicians or urgent care centers <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 <p>Note: For routine post-operative surgical care, see Section 5(b) <i>Surgical procedures</i>.</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
Not covered: <ul style="list-style-type: none"> • <i>Routine eye and hearing examinations</i> • <i>Nonsurgical treatment for weight reduction or obesity</i> 	<i>All charges.</i>

Benefit Description	You Pay After calendar year deductible
Lab, X-ray and other diagnostic tests	
<p>Tests and their interpretation, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram (EKG) • Electroencephalogram (EEG) • Osteoporosis screening <p>Note: When tests are performed during an inpatient confinement, no deductible applies.</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>Lab Savings Program - You can use this voluntary program for covered lab services. As long as Quest Diagnostics does the testing and bills us directly, you will not have to file any claims. Ask your doctor to use Quest for lab processing. To find a location near you, call 1-800-622-6252, or visit our Web site at www.nalc.org/depart/hbp.</p>	<p>Nothing, for services obtained through the Lab Savings Program (No deductible)</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 immunizations endorsed by the Centers for Disease Control and Prevention (CDC), 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> in this section) • Tetanus-diphtheria, pertussis (Tdap) booster—one, age 19 through 64 (except as provided for under <i>Preventive care, children</i> in this section) • Varicella (chickenpox) vaccine—adults age 19 through 49 • Influenza vaccine—one annually • Pneumococcal vaccine, age 65 and older <p>Routine screenings, limited to:</p> <ul style="list-style-type: none"> • 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> <ul style="list-style-type: none"> • Chlamydial infection test 	<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>

Preventive care, adult - continued on next page

Benefit Description	You Pay After calendar year deductible
Preventive care, adult (cont.)	
<ul style="list-style-type: none"> • Total blood cholesterol—one every three years • Fasting Lipoprotein Profile (total cholesterol, LDL, HDL, and triglycerides)—one every 5 years, age 20 and older • Prostate Specific Antigen (PSA) test—one annually for men, age 40 and older • Abdominal aortic aneurysm screening by ultrasonography—one in a lifetime, for men ages 65 through 75 with smoking history • Osteoporosis screening—for women with increased risk, age 60 and older • 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 - Ages 65 and older, one every two consecutive calendar years • Colorectal cancer screening, including: <ul style="list-style-type: none"> - Fecal occult blood test—one annually, age 40 and older - Double Contrast Barium Enema (DCBE)—one every five years, age 50 and older <p>Note: To reduce your out-of-pocket costs for laboratory services, see <i>Lab Savings Program</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>
<ul style="list-style-type: none"> • Sigmoidoscopy screening—one every five years, age 50 and older • Colonoscopy screening—one every 10 years, age 50 and older 	<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>
<p>Routine physical exam, one —annually, age 22 or older</p>	<p>PPO: \$20 copayment per visit (No deductible)</p> <p>Non-PPO: 30% of the Plan allowance and the difference, if any, between the Plan allowance and the billed amount</p>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations, ages 3 through 21, limited to: <ul style="list-style-type: none"> - Immunizations recommended by the American Academy of Pediatrics - Meningococcal immunization—lifetime limit of two vaccinations • Well-child care—routine examinations and immunizations, through age 2 	<p>PPO: Nothing (No deductible)</p> <p>Non-PPO: The difference, if any, between our allowance and the billed amount (No deductible)</p>

Preventive care, children - continued on next page

Benefit Description	You Pay After calendar year deductible
Preventive care, children (cont.)	
<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 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>
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care • Amniocentesis 	<p>PPO: Nothing (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"> • 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. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • The circumcision charge for an infant covered under a Self and Family enrollment is payable under surgical benefits. See Section 5(b) <i>Surgical procedures</i>. • We pay hospitalization and surgeon services (delivery) at 100% of Plan allowance when you use a PPO provider. 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>

Benefit Description	You Pay After calendar year deductible
Family Planning	
Voluntary family planning services, limited to: <ul style="list-style-type: none"> • Voluntary sterilization (see Section 5(b) <i>Surgical procedures</i>) • Implanted contraceptives • Intrauterine devices (IUDs) 	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
<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) <i>Surgical procedures</i> . 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> Infertility services after voluntary sterilization Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> - Artificial insemination - In vitro fertilization - <i>Embryo transfer and gamete intrafallopian transfer (GIFT)</i> Services and supplies related to ART procedures Cost of donor sperm Cost of donor egg	<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>	<i>All charges.</i>

Allergy care - continued on next page

Benefit Description	You Pay After calendar year deductible
Allergy care (cont.)	
<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"> • Intravenous (IV)/Infusion Therapy—Home IV and antibiotic therapy • Respiratory and inhalation therapies • Growth hormone therapy (GHT) <p>Note: Specialty drugs, including biotech drugs, available through Caremark Specialty Pharmacy Services are covered only under the Prescription drug benefit. See Section 5(f) <i>Prescription drug benefits</i>.</p> <p>Note: Prior approval is required for certain specialty drugs used to treat chronic medical conditions, such as allergic asthma, hepatitis C, psoriasis, growth hormone disorder, rheumatoid arthritis, and respiratory syncytial virus (RSV). See instructions for approval in Section 5(f) Prescription drug benefits—<i>These are the dispensing limitations</i>.</p> <ul style="list-style-type: none"> • Dialysis—hemodialysis and peritoneal dialysis • Chemotherapy and radiation therapy <p>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>.</p> <p>Note: Oral chemotherapy drugs available through Caremark are covered only under the Prescription drug benefit. Section 5(f) <i>Prescription drug benefits</i>—<i>These are the dispensing limitations</i>.</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: Chelation therapy, except as treatment for acute arsenic, gold, lead, or mercury poisoning</i></p>	<i>All charges</i>
Physical and occupational therapies	
<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; 	<p>PPO: 15% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Physical and occupational therapies - continued on next page

Benefit Description	You Pay After calendar year deductible
Physical and occupational therapies (cont.)	
<ul style="list-style-type: none"> 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 any difference between our allowance and the billed amount</p>
Cardiac rehabilitation 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>
<i>Not covered: Exercise programs and maintenance therapy</i>	<i>All charges</i>
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>
<i>Not covered: Maintenance therapy</i>	<i>All charges</i>
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"> <i>Routine hearing testing</i> <i>Hearing aid and examination, except when necessitated by accidental injury</i> 	<i>All charges</i>

Benefit Description	You Pay After calendar year deductible
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Eye examinations for covered diagnoses, such as cataract, diabetic retinopathy and glaucoma 	PPO: \$20 copayment per visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
<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) when purchased within one year <p>Note: For examinations for amblyopia and strabismus, see <i>Preventive care, children</i> in this section.</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><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Eyeglasses or contact lenses and examinations for them, except as described above</i> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy and other refractive surgery</i> <i>Refractions</i> 	<p><i>All charges</i></p>
Foot care	
<ul style="list-style-type: none"> Nonsurgical routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes 	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
<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 Extracorporeal shock wave treatment (when symptoms have existed for at least 6 months and other standard methods of treatment have been unsuccessful) 	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
<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 heel cups</i> <i>Orthopedic and corrective shoes</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay After calendar year deductible
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</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>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>Bionic prosthetics</i> Prosthetic replacements provided less than 3 years after the last one we covered 	<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>Note: Call us at 703-729-4677 or 1-888-636-NALC (6252) as soon as your physician prescribes equipment or supplies. We have arranged with a health care provider to rent or sell durable medical equipment at discounted rates and will tell you more about this service when you call.</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>

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay After calendar year deductible
Durable medical equipment (DME) (cont.)	
<p>We cover rental or purchase (at our option) including repair and adjustment of durable medical equipment, such as:</p> <ul style="list-style-type: none"> • Oxygen and oxygen apparatus • Dialysis equipment • Hospital beds • Wheelchairs • Crutches, canes, and walkers <p>We also cover supplies, such as:</p> <ul style="list-style-type: none"> • Insulin and diabetic supplies • Needles and syringes for covered injectables • Ostomy and catheter supplies 	<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 (including rental) 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, and elevators</i> • <i>Modifications or alterations to vehicles or households</i> • <i>Equipment or devices, such as iBOT Mobility System that allow increased mobility, beyond what is provided by standard features of DME</i> • <i>Other items (such as wigs) that do not meet the criteria 1 thru 6 on page 27.</i> 	<p><i>All charges</i></p>
Home health services	
<p>Up to 50 days per calendar year (with a maximum Plan payment of \$135 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 	<p>PPO: 20% of the Plan allowance (No deductible) and all charges after we pay \$135 per day</p> <p>Non-PPO: 20% of the Plan allowance (No deductible) and all charges after we pay \$135 per day</p>

Benefit Description	You Pay After calendar year deductible
Home health services (cont.)	
<p>The physician indicates the length of time the services are needed.</p>	<p>PPO: 20% of the Plan allowance (No deductible) and all charges after we pay \$135 per day</p> <p>Non-PPO: 20% of the Plan allowance (No deductible) and all charges after we pay \$135 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	
<p>Limited to:</p> <ul style="list-style-type: none"> • Initial set of spinal x-rays • 12 spinal manipulations per calendar year <p>Note: The above services rendered by a chiropractor in medically underserved areas are subject to these limitations. Benefits may be available for other covered services you receive from a chiropractor in medically underserved areas.</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: Any treatment not specifically listed as covered</i></p>	<p><i>All charges</i></p>
Alternative treatments	
<p>Acupuncture, limited to treatment by a doctor of medicine or osteopathy for pain relief</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: Naturopathic services</i></p> <p>Note: In medically underserved areas, we may cover services of alternative treatment providers. See Section 3 <i>Covered providers</i>.</p>	<p><i>All charges</i></p>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • 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 	<p>PPO: Nothing for the first \$100 (No deductible)</p> <p>Non-PPO: Nothing for the first \$100 (No deductible)</p>
<ul style="list-style-type: none"> • Educational classes and nutritional therapy for self-management of diabetes when: <ul style="list-style-type: none"> - Prescribed by the attending physician, and - Administered by a covered provider, such as a registered nurse or a licensed or registered dietician/nutritionist. 	<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>

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You Pay After the calendar year deductible...
Note: The calendar year deductible applies ONLY when we say below: “(calendar year deductible applies)”.	
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 of breasts - Treatment of any physical complications, such as lymphedemas 	<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

Benefit Description	You Pay After the calendar year deductible...
Reconstructive surgery (cont.)	
<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>
<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"> • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures 	<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>

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	<p>Nothing for services obtained through the National Transplant Program. (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>Blood or marrow stem cell transplants limited to the stages of the following diagnoses (Note: The medical necessity limitation is considered satisfied, if the patient meets the staging description and can safely tolerate the procedure):</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Advanced neuroblastoma • Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer) <p>Blood or marrow stem cell transplants limited to:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis - Leukocyte adhesion deficiencies 	<p>Nothing for services obtained through the National Transplant Program. (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

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Mucopolysaccharidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) - Thalassemia major (homozygous beta-thalassemia) - X-linked lymphoproliferative syndrome • Autologous transplants for: <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer 	<p>Nothing for services obtained through the National Transplant Program. (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>Blood or marrow stem cell transplants covered only in a National Cancer Institute (NCI) or National Institutes of Health (NIH) approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols limited to:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Breast cancer - Epithelial ovarian cancer 	<p>Nothing for services obtained through the National Transplant Program (No deductible)</p>
<p>National Transplant Program—The Plan participates in the Coventry Health Care National Transplant Program. Before your initial evaluation as a potential candidate for a transplant procedure, you or your physician must contact Coventry Health Care at 1-800-622-6252 and speak to a Transplant Case Manager. You will be given information about this program including a list of participating providers. Charges for services performed by a National Transplant Program provider, whether incurred by the recipient or donor are paid at 100%. Participants in the program must obtain prior approval from the Plan to receive limited travel and lodging benefits.</p>	<p>Nothing for services obtained through the National Transplant Program (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Travel and lodging expenses, except when approved by the Plan</i> • <i>Implants of artificial organs</i> 	<p><i>All charges</i></p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> • <i>Transplants and related services and supplies not listed as covered</i> 	<i>All charges</i>
Surgical procedures	
<p>Limited Benefits—If you do not obtain prior approval or do not use a designated facility, or if we are not the primary payer, we pay a maximum of \$100,000 for each listed transplant (kidney limit, \$50,000), for these combined expenses: pre-transplant evaluation; organ procurement; and inpatient hospital, surgical and medical expenses. We pay benefits according to the appropriate benefit section, such as Section 5(c) <i>Inpatient hospital</i>, and <i>Surgical procedures</i>. The limitation applies to expenses incurred by either the recipient or donor.</p> <p>Note: Some transplants listed may not be covered through the National Transplant Program.</p> <p>Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.</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>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 • Surgical treatment of morbid obesity (bariatric surgery) is covered when: <ul style="list-style-type: none"> 1) Clinical records support a body mass index (BMI) of 40 or greater, or 35 or greater with high-risk comorbid conditions such as cardiopulmonary problems or severe diabetes mellitus. 2) The patient has participated in a weight-loss program, of at least six months duration, that includes dietary therapy, physical activity and behavior modification. This physician supervised program must be documented and have occurred within a reasonable time period prior to the surgery. 3) A repeat or revised bariatric surgical procedure is covered only when medically necessary or a complication has occurred, such as a fistula, obstruction, or disruption of a suture/staple line. 	<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

Benefit Description	You Pay After the calendar year deductible...
Surgical procedures (cont.)	
<p>4) The patient is age 18 or older.</p> <ul style="list-style-type: none"> • Insertion of internal prosthetic devices. See Section 5(a) <i>Orthopedic and prosthetic devices</i>, for device coverage information. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Surgically implanted contraceptives • 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 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, gingival and alveolar bone)</i> • <i>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</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Procedures performed through the same incision deemed incidental to the total surgery, such as appendectomy, lysis of adhesion, puncture of ovarian cyst</i> • <i>Reversal of voluntary sterilization</i> • <i>Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standby surgeons are medically necessary</i> • <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 listed under Section 5(a) Foot care</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay After the calendar year deductible...
Anesthesia	
Professional services provided in: <ul style="list-style-type: none"> • Hospital (inpatient) Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for the anesthesia charges.	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (No deductible)
Professional services provided in: <ul style="list-style-type: none"> • Hospital outpatient department • Ambulatory surgical center • Office • Other outpatient facility Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for the anesthesia charges.	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(c) Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

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

Benefit Description	You Pay
Note: The calendar year deductible applies ONLY when we say below: “(calendar year deductible applies)”.	
Inpatient hospital	
Room and board, such as: <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • Birthing room • General nursing care; and • Meals and special diets. <p>Note: Your coinsurance expenses for inpatient services billed by PPO hospital facilities will never exceed \$2000.</p> <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>	PPO: Nothing when services are related to the delivery of a newborn. 10% of the Plan allowance for all other admissions. Non-PPO: \$100 copayment per admission and 30% of the Plan allowance

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
<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>	<p>PPO: Nothing when services are related to the delivery of a newborn. 10% of the Plan allowance for all other admissions.</p> <p>Non-PPO: \$100 copayment per admission and 30% of the Plan allowance</p>
<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), limited to: <ul style="list-style-type: none"> - Chest X-rays - Electrocardiograms - Urinalysis - Blood work • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Internal prostheses • Professional ambulance service to the nearest hospital equipped to handle your condition • Occupational, physical, and speech therapy <p>Note: Your coinsurance expenses for inpatient services billed by PPO hospital facilities will never exceed \$2000.</p> <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>Note: Diagnostic tests, such as magnetic resonance imaging, throat cultures, or similar studies are not considered as preadmission testing.</p>	<p>PPO: Nothing when services are related to the delivery of a newborn. 10% of the Plan allowance for all other admissions.</p> <p>Non-PPO: \$100 copayment per admission and 30% of the Plan allowance</p>
Take-home items	PPO: 15% of the Plan allowance (calendar year deductible applies)

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • Medical supplies, appliances, and equipment; and any covered items billed by a hospital for use at home 	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance (calendar year deductible applies)
<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 subacute care, long term care, long term acute care, intermediate care, or when you do not need acute hospital inpatient care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting.</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> 	<i>All charges</i>
Outpatient hospital or ambulatory surgical center	
<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, splints, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: For accidental injuries and medical emergencies see Section 5(d) <i>Emergency services/accidents</i>.</p> <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>	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay
Outpatient hospital or ambulatory surgical center (cont.)	
<p>Plan pays for pre-operative testing within 7 days of surgery. Screening tests, limited to:</p> <ul style="list-style-type: none"> • Chest X-rays • Electrocardiograms • Urinalysis • Blood work <p>Note: To reduce your out-of-pocket costs for laboratory services, see Section 5(a) <i>Lab Savings Program</i>.</p> <p>Note: Diagnostic tests, such as magnetic resonance imaging, throat cultures, or similar studies are not considered as preadmission testing.</p>	<p>PPO: 10% of the Plan allowance</p> <p>Non-PPO: 30% of the Plan allowance (No deductible), and the difference, if any, between our allowance and the billed amount</p>
<i>Not covered: Personal comfort items</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits	
<p>Limited to care in a skilled nursing facility (SNF) when your Medicare Part A is primary, and:</p> <ul style="list-style-type: none"> • Medicare has made payment, we cover the applicable copayments; or • Medicare's benefits are exhausted, we cover semiprivate room, board, services, and supplies in a SNF, for the first 30 days of each admission or readmission to a facility, provided: <ol style="list-style-type: none"> 1. You are admitted directly from a hospital stay of at least 3 consecutive days; 2. You are admitted for the same condition as the hospital stay; and 3. Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N. 	<p>PPO: Nothing</p> <p>Non-PPO: Nothing</p>
<i>Not Covered: Custodial care</i>	<i>All charges</i>
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> 	<i>All charges</i>

Benefit Description	You Pay
Ambulance	
<ul style="list-style-type: none"> Local professional ambulance service when medically necessary 	<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

Important things you should keep in mind about these benefits:

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

What is an accidental injury?

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

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

Benefit Description	You pay After the calendar year deductible...
Medical emergency	
Outpatient medical services and supplies except physicians' and urgent care center office visits. See Section 5(a) <i>Medical services and supplies...</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
Professional services of physicians and urgent care centers • 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
Surgical services. See Section 5(b) <i>Surgical procedures.</i>	PPO: 10% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Ambulance	
Local professional ambulance service when medically necessary, not related to an accidental injury	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
<i>Not covered: Transportation (other than professional ambulance services), such as by ambulance or medicab</i>	<i>All charges</i>

Section 5(e) Mental health and substance abuse benefits In-Network Benefits

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is a separate calendar year deductible for In-Network mental health and substance abuse of \$250 per person (\$500 per family). This calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” to show when the calendar year deductible does not apply.
- When no In-Network provider is available or covered services are not preauthorized, Out-of-Network benefits will be paid.
- Be sure to read Section 4 *Your costs for covered services*, for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9 *Coordinating benefits with other coverage*.
- **YOU MUST GET PREAUTHORIZATION 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 52.

Benefit Description	You Pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
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 illnesses or conditions, such as \$20 copayment per office visit, or 15% of the Plan allowance for other outpatient services after the calendar year deductible is met.</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
<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

In-Network benefits - continued on next page

Benefit Description	You Pay After the calendar year deductible...
In-Network benefits (cont.)	
<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 <p>Note: Your coinsurance expenses for inpatient services billed by hospitals or other facilities will never exceed \$2000.</p>	10% of the Plan allowance (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.

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

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

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

Where to file claims

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

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

Section 5(e) Out-of-Network Benefits

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible for inpatient and outpatient professional services is \$300 per person (\$600 per family). The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” to show when the calendar year deductible does not apply.
- The calendar year deductible in a treatment facility is \$300 per person.
- Be sure to read Section 4 *Your costs for covered services*, for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 7 *Filing a claim for covered services* and Section 9 *Coordinating benefits with other coverage*.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A \$500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.	
Out-of-Network benefits	
Inpatient and outpatient professional services of providers, such as psychiatrists, psychologists, clinical social workers, or community mental health organizations: <ul style="list-style-type: none"> • 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 half-way houses, and members of their staffs</i> 	<i>All charges</i>

Out-of-Network benefits - continued on next page

Benefit Description	You pay After the calendar year deductible...
Out-of-Network benefits (cont.)	
Note: In medically underserved areas, we may cover services of pastoral counselors. See Section 3 <i>Covered providers.</i>	<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 30755
Salt Lake City, UT 84130-0755
Questions? 1-877-468-1016

Section 5(f) Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed medications and supplies as described in the chart beginning on page 48.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year drug deductible of \$25 per person or \$50 per family applies only to non-network benefits. The calendar year deductible applies ONLY when we say “(calendar year deductible applies).”
- **SOME DRUGS REQUIRE PRIOR APPROVAL** before we provide benefits for them. Refer to the dispensing limitations on this page for further information.
- Maximum dosage dispensed may be limited by protocols established by the Plan.
- In the event of a disaster or an emergency where additional or early fills of medications are needed, call the Plan at 703-729-4677 or 1-888-636-NALC (6252) for authorization.
- When we say “Medicare” in the *You pay* section we mean you have Medicare Part B or Part D and it is primary.
- Be sure to read Section 4 *Your costs for covered services*, for valuable information about cost sharing, with special sections for members who are age 65 or older. Also read Section 9 *Coordinating benefits with other coverage*.

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

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

NALC Prescription Drug Program
P.O. Box 94465
Palatine, IL 60094-4465
- **We use a formulary.** Our formulary is open and voluntary. If your physician believes a brand name drug is necessary, or if there is no generic available, ask your physician to prescribe a brand name drug from our formulary list. These preferred brand name drugs are selected to meet patient needs at a lower cost. To order the formulary pamphlet, call 1-800-933-NALC (6252).
- **These are the dispensing limitations.** You may obtain up to a 30-day fill plus one refill for each prescription purchased at a network retail pharmacy. Maintenance and long-term medications may be ordered through our Mail Order Prescription Drug Program for up to a 60-day or 90-day supply (21-day minimum). No deductible applies. You cannot obtain a refill until 75% of the drug has been used. Network retail pharmacy limitations are waived when you have Medicare Part D as your primary payer and they cover the drug.

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

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

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

Decisions about prior approval are based on guidelines developed by physicians at the FDA or independent expert panels and are administered by Caremark's pharmacy experts. Medications dispensed through the mail order program are subject to the following standards: the professional judgment of the pharmacist, limitations imposed on controlled substances, manufacturer's recommendations, and applicable state law.

- **A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name.** If you receive a brand name drug when a federally-approved generic drug is available, and your physician has not specified "Dispense as Written" for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name. The brand name is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic drug costs you—and us—less than a brand name drug.
- **When you have Medicare Part D.** We waive the following at retail when Medicare Part D is primary payer and covers the drug:
 - Refill limitations
 - Day supply
 - Calendar year drug deductible

Note: See Section 9 *Coordinating benefits with other coverage*, for more information on Medicare Part D.

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

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

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

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

Benefit Description	You Pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</p>	
<p>Covered medications and supplies</p>	
<p>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, when the dysfunction is caused by medically documented organic disease <p>Note: Mail order copayments do not apply to 60-day or 90-day purchases at retail pharmacies.</p> <p>Note: If there is no generic equivalent available, you pay the brand name copay.</p>	<p>Retail:</p> <ul style="list-style-type: none"> • Preferred network/Network retail: 25% of cost • Non-network retail: 50% of the Plan allowance, and the difference, if any, between our allowance and the billed amount (calendar year deductible applies) <p>Retail Medicare:</p> <ul style="list-style-type: none"> • Preferred network/Network retail Medicare: 15% of cost • Non-network retail Medicare: 50% of the Plan allowance, and the difference, if any, between our allowance and the billed amount <p>Mail order:</p> <ul style="list-style-type: none"> • 60-day supply: \$8 generic/\$24 brand name • 90-day supply: \$12 generic/\$35 brand name <p>Mail order Medicare:</p> <ul style="list-style-type: none"> • 60-day supply: \$7 generic/\$20 brand name • 90-day supply: \$10 generic/\$30 brand name
<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> • <i>Drugs for smoking cessation, except as described in Section 5(a) Educational Classes and Programs</i> <p><i>Note: See Section 5(g) Special Features for information on the CaremarkDirect Program where you may obtain non-covered medications at a discounted rate.</i></p>	<p><i>All charges</i></p>

Section 5(g) Special features

Special feature	Description
CaremarkDirect Program	<p>You can purchase non-covered drugs through the Caremark mail service pharmacy and receive the convenience, safety, and confidentiality you already benefit from with covered prescriptions. CaremarkDirect is offered at no additional charge to you. Using the mail service program for both covered and non-covered prescriptions will help ensure overall patient safety.</p> <p>CaremarkDirect is a value-added program that provides you with safe, convenient access to competitively priced, non-covered prescriptions, and certain over-the-counter drugs.</p> <p>You may call 1-800-933-NALC (6252), 24 hours a day, 7 days a week, for a complete listing of available medications and their cost.</p>
Disease management programs	<p>These programs offer a considerable amount of personalized attention from clinicians and program educators who are available to discuss lifestyle changes, therapeutic outcomes, and other health related matters to assist patients in dealing with their experiences. Support is available for patients with allergic asthma, chronic heart failure, coronary artery disease, coronary heart failure, chronic obstructive pulmonary disease, diabetes, growth hormone disorder, hepatitis C, psoriasis, rheumatoid arthritis, respiratory syncytial virus, transplants, and ulcers.</p>
Enhanced Eldercare Services	<p>For members or spouses that are caring for an elderly relative or disabled dependent, this program provides expert assistance from a Care Advocate, a registered nurse with geriatric, disability and community health experience. Your benefit gives you a bank of six free hours per calendar year, which may be used for any combination of the following services:</p> <ul style="list-style-type: none"> • Evaluating the elder's/dependent's living situation • Identifying medical, social and home needs (present and future) • Recommending a personalized service plan for support, safety and care • Finding and arranging all necessary services • Monitoring care and adjusting the service plan when necessary <p>Whether it's arranging transportation to doctors' appointments, explaining insurance options, having safety equipment installed, or coordinating care with multiple providers, the Care Advocate will help ensure that your elderly relative or disabled dependent maintains a safe, healthy lifestyle.</p> <p>You also have the option to purchase continuing services beyond the six hours offered.</p> <p>You may call 1-877-468-1016, 24 hours a day, 7 days a week, to access Enhanced Eldercare Services. Hours of operation are 8:00 a.m. to 8:30 p.m. (Pacific time), with a Care Advocate on call after hours and on weekends.</p>
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. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future.

	<ul style="list-style-type: none"> • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
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>TTY lines are available for the following:</p> <p>CAREMARK: 1-800-238-1217 (prescription benefit information)</p> <p>Coventry Health Care: 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>
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 an 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. This policy may be purchased throughout the year and is not subject to the health benefit plan open season.

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

Hospital Plus allows you to choose the amount of coverage you need. You may elect to receive a \$100 a day, \$75 a day, \$50 a day, or \$30 a day plan. Members can insure their spouses and eligible children also. The spousal coverage is the same as the member's. Children's coverages are limited to \$60 a day, \$45 a day, \$30 a day, or \$18 a day plans. Benefits will be based on the number of days in the hospital, up to 365 days or as much as \$36,500 (if a \$100 a day benefit is chosen).

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

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

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

Important Notice Regarding Membership Dues

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

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

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

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

Section 6 General exclusions – things we don't cover

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

We do not cover the following:

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

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

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

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements, except as required by the HIPAA Privacy Rule. See Section 1 *Facts about this fee-for-service plan*.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

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

When we need more information

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

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

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies—including a request for preauthorization/prior approval (see Section 3 *How to get approval for...*).

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> a) Write to us within 6 months from the date of our decision; b) Send your request to us at: NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149; c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits statements.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); b) Write to you and maintain our denial—go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within:</p> <ul style="list-style-type: none"> • 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits statements; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

	<p>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.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<p>5</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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

- We haven’t responded to your initial request for care or preauthorization/prior approval, then call us at 703-729-4677 or 1-888-636-NALC (6252) and we will expedite our review; or
- We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they too can expedite your request, or
 - You may call OPM’s Health Insurance Group 2 at 202-606-3818 between 8:00 a.m. and 5:00 p.m., Eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about our prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

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

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

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

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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

Claims process when you have the Original Medicare Plan—You probably will not need to file a claim form when you have both our Plan and the Original Medicare Plan.

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

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

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

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

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

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

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

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

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

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

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

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you?	The primary payer for the individual with Medicare is?	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) 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	✓ *	
B. When you or a covered family member?		
1) Have Medicare solely based on end stage renal disease (ESRD) and • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you?		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

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

**TRICARE and
CHAMPVA**

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

**When other Government
agencies are responsible
for your care**

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

**When others are
responsible for injuries**

Subrogation/Reimbursement guidelines: If your illness or injury is caused by the act or omission of a third party, the Plan has the right to reimbursement of benefits paid on your behalf from any recovery made to you by a third party or third party's insurer. "Third party" means another person or organization. Our right to reimbursement is limited to the benefits we have paid or will pay to you or on your behalf related to the illness or injury.

You must notify us promptly if you are seeking a recovery from a third party because of the act or omission of another person. Further, you must keep the Plan advised of developments in your claim and promptly notify us of any recovery you receive, whether in or out of court. You must reimburse us to the extent the Plan paid benefits. You have the right to retain any recovery that exceeds the amount of the Plan's subrogation claim.

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

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

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

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 cost 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, sometimes called “long term 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 service

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

A medical treatment or procedure, or a drug, device, or biological product is considered experimental or investigational if reliable evidence shows that:

- It is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis; or
- The consensus of opinion among experts is that further studies or clinical trials are necessary to determine its toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis.

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

Group health coverage

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

Medical necessity

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

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

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

Mental health and substance abuse

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

Plan allowance

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

PPO benefits:

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

In-Network mental health and substance abuse benefits:

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

Non-PPO benefits:

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

- If you receive care in an area that has a fully developed PPO network (one in which you have adequate access to a PPO provider, regardless of the availability of a specialist), we use the average PPO rate for your area. This non-PPO allowance represents an average of the PPO fee schedules for a particular service in a geographic area. We call this our “average fee schedule”;
- If you do not have adequate access to a PPO provider, our Plan allowance is based on the 80th percentile of data gathered from health care sources that compare charges of other providers for similar services in the same geographic area; or
- For medication charges, our allowance is based on the average wholesale price.

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

Our allowance is based on the 80th percentile of data gathered from health care sources that compare charges of other providers for similar services in the same geographic area when you:

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

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

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

Preadmission testing

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

Us/We

Us and We refer to the NALC Health Benefit Plan.

You

You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

See www.opm.gov/insure/health for enrollment information as well as:

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

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

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

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

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

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status (divorce or marries).

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

- **Children’s Equity Act** OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

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

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

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

- **When benefits and premiums start** The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB at the end of the year, you are covered under that plan’s 2006 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

When you lose benefits

- **When FEHB coverage ends** You will receive an additional 31 days of coverage, for no additional premium, when:
 - Your enrollment ends, unless you cancel your enrollment; or
 - You are a family member no longer eligible for coverage.

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

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the Spouse Equity Law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

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

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal 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. It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12 Three Federal Programs complement FEHB benefits

Important information

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

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

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis.

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program (FLTCIP)**?

FEHB plans do not cover the cost of long term care. Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.

The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care. This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.

It's to your advantage to apply sooner rather than later. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. . If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.

Qualified relatives are also eligible to apply. Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

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

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse, if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums)

For the LEX HCFSA – Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums)

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit www.FSAFEDS.com.

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

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

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

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

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

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

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dental/vision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment web site sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

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

Summary of benefits for the NALC Health Benefit Plan - 2007

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the \$250 PPO or \$300 Non-PPO calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> Diagnostic and treatment services provided in the office 	PPO: \$20 copayment per office visit; \$5 copayment per allergy injection; routine screening services and other nonsurgical services, 15%* of our allowance Non-PPO: 30%* of our allowance	25
Services provided by a hospital:		
<ul style="list-style-type: none"> Inpatient 	PPO: Nothing when services are related to the delivery of a newborn. 10% of our allowance for all other admissions. Non-PPO: \$100 copayment per admission and 30% of our allowance	43
<ul style="list-style-type: none"> Outpatient 	PPO: 15%* of our allowance Non-PPO: 30%* of our allowance	45
Emergency benefits:		
<ul style="list-style-type: none"> Accidental injury 	Within 72 hours: Nothing for nonsurgical outpatient care After 72 hours: PPO: 15%* of our allowance Non-PPO: 30%* of our allowance	48
<ul style="list-style-type: none"> Medical emergency 	Regular cost sharing	49
Mental health and substance abuse treatment:		
	In-Network: Regular cost sharing	50
	Out-of-Network: Benefits are limited	52
Prescription drugs:		
<ul style="list-style-type: none"> Retail pharmacy 	Preferred Network/Network retail: 25% of cost Preferred Network/Network retail Medicare: 15% of cost Non-network retail: \$25 deductible and 50% of our allowance Non-network retail Medicare: 50% of our allowance	56
<ul style="list-style-type: none"> Mail order 	Mail order: 60-day supply, \$8 generic/\$24 brand name Mail order: 90-day supply, \$12 generic/\$35 brand name	56

	Mail order Medicare: 60-day supply, \$7 generic/\$20 brand name Mail order Medicare: 90-day supply, \$10 generic/\$30 brand name	
Dental care:	All charges.	59
Special features:	<ul style="list-style-type: none"> • CaremarkDirect • Disease management programs • Eldercare Enhanced Services • Flexible benefits option • 24-hour nurse line • 24-hour help line for mental health and substance abuse • Services for deaf and hearing impaired • Worldwide coverage 	57
Protection against catastrophic costs (out-of-pocket maximum):	<p>Services with coinsurance (excluding mental health and substance abuse care), nothing after your coinsurance expenses total:</p> <ul style="list-style-type: none"> • \$4000 for PPO providers/facilities • \$6000 for Non-PPO providers/facilities. When you use a combination of PPO and Non-PPO providers your out-of-pocket expense will not exceed \$6000. • Your coinsurance expenses for inpatient services billed by PPO hospital facilities will never exceed \$2000. <p>Mental health and substance abuse benefits, nothing after your coinsurance expenses total:</p> <ul style="list-style-type: none"> • \$4000 for In-Network mental health and substance abuse providers/facilities • \$8000 for Out-of-Network mental health and substance abuse inpatient hospital treatment (after 50 days you pay all charges) • Your coinsurance expenses for inpatient services billed by In-Network hospitals or other facilities will never exceed \$2000. <p>Some costs do not count toward this protection.</p>	19

2007 Rate Information for the NALC Health Benefit Plan

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

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

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	321	141.92	64.42	307.49	139.58	167.54	38.8
High Option Self and Family	322	321.89	118.97	697.43	257.77	380.01	60.85