NALC Health Benefit Plan

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

Customer Service 1-888-636-NALC (6252)

National Association of Letter Carriers

2013

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).

IMPORTANT
- Rates: Back Cover
- Changes for 2013: Page 18
- Summary of benefits: Page 108

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. See page 82 and the back cover for more details.
- 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 82 and the back cover for more details.

Membership dues: NALC dues vary by local branch for Postal employees.

Associate members will be billed by the NALC for the $36 annual membership fee, except where exempt by law.

Call Membership at 202-662-2856 for inquires regarding membership, union dues, fees, or information on the NALC union.

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

Enrollment codes for this Plan:

321 Self Only
322 Self and Family

Joint Commission accreditation: CVS/Caremark's 15 Specialty pharmacies and MinuteClinics, Alere™ URAC accreditation: Alere™ Case Management, CVS/Caremark's Mail and Specialty Pharmacies, Pharmacy Benefit Management, and CVS/Caremark Drug Therapy Management; Cigna HealthCare Case Management and Health Utilization Management, and Health Call Center; and OptumHealth Behavioral Solutions Health Utilization Management NCQA accreditation: CVS/Caremark's 16 Health Management Programs, Alere's™ 5 Health Management Programs and Cigna HealthCare OAP Network, OptumHealth Behavioral Solutions Health Utilization Management

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
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 cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) 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 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. Customer Service may be reached at 1-888-636-NALC (6252) or through our Web site: www.nalc.org/depart/hbp. The address and phone number for the NALC Health Benefit Plan administrative office is:

NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149
703-729-4677 or 1-888-636-NALC (6252)

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, 2013, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2013, and changes are summarized on page 18. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means the 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.

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.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- 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
877-499-7295
OR go to www.opm.gov/oig
You can also 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 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- 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.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

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 and their dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist 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.

Patient Safety Links

- www.ahrq.gov/consumer. 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.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital-acquired conditions or for inpatient services needed to correct never events, if you use (Cigna HealthCare Shared Administration OAP Network) preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs neither your FEHB plan nor you will incur costs to correct the medical error.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

  - When you may change your enrollment
  - How you can cover your family members
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
  - What happens when your enrollment ends
  - 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. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 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 benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

  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.

  If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB Web site at www.opm.gov/insure/lifeevents. If you need assistance, please contact your employing agency, personnel/payroll office, or retirement office.

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse and children as described in the chart below:

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

- **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 2013 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 2012 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.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from the provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

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

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn age 26, regardless of marital status.

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 1. How this plan works

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

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

General features of our Plan

We have a Preferred Provider Organization (PPO):

Our fee-for-service plan offers services through a PPO. This means that certain hospitals and other health care providers are "preferred providers". When you use our PPO providers, you will receive covered services at reduced cost. Cigna HealthCare is solely responsible for the selection of PPO providers in your area. Call 1-877-220-NALC (6252) for the names of PPO providers or call us at 703-729-4677 or 1-888-636-NALC (6252) to request a PPO directory. We recommend that you call the PPO provider you select before each visit and verify they continue to participate in the Cigna HealthCare Shared Administration Open Access Plus (OAP) Network. You can also go to our Web page, which you can reach through the FEHB Web site, www.opm.gov/insure.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. However, if the surgical services (including maternity) are rendered at a PPO hospital by a PPO physician, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level. In addition, we will pay medical emergencies specifically listed in Section 5(d). *Medical emergency* at the PPO benefit level. For members in the state of Alaska, non-PPO surgeons contracted through the MultiPlan (Viant) network will be paid at the PPO benefit level. For members in the Commonwealth of Puerto Rico, all non-PPO physicians, hospitals, and facilities contracted through Coalition America (NPPN) will be paid at the PPO benefit level.

How we pay providers

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

Non-PPO facilities and providers do not have special agreements with us. Our payment is based on our allowance for covered services. You may be responsible for amounts over the allowance. We also obtain discounts from some non-PPO providers. When we obtain discounts through negotiation with non-PPO providers we share the savings with you.

Your rights

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

- The NALC Health Benefit Plan has been part of the FEHB Program since July 1960.
- We are a not-for-profit health plan sponsored and administered by the National Association of Letter Carriers (NALC), AFL-CIO.
- Our preferred provider organization (PPO) is Cigna HealthCare Shared Administration OAP Network.
- Our network provider for mental health and substance abuse benefits is OptumHealth**SM** Behavioral Solutions (comprised of United Behavioral Health, a UnitedHealth Group company).
- Our prescription drug retail network is the NALC CareSelect Network.
- Our mail order prescription program and specialty pharmacy services are through Caremark.

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

Your medical and claims records are confidential

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

Notice of the NALC Health Benefit Plan's Privacy Practices

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

I. Understanding Your Health Record/Information

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

II. Our Privacy Practices

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

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

III. Uses and Disclosures of Protected Health Information

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

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

- Example (treatment): Based upon the PHI in your file, we may contact your physician and discuss possible drug interactions or duplicative therapy.
- Example (payment): We disclose PHI when we ask your physician to clarify information or to provide additional information if your claim form is incomplete.
- Examples (health care operations): We disclose PHI as part of our routine health care operations when we submit individual claims or files for audits. We may use and disclose your protected health information as part of our efforts to uncover instances of provider abuse and fraud. Or, we may combine the protected health information of many participants to help us decide on services for which we should provide coverage.

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

- To Business Associates: We contract with business associates to provide some services. Examples include, but are not limited to, our Preferred Provider Organization and Prescription Drug Program. When these services are contracted, we may disclose your PHI to our business associates so that they can perform the job we've asked them to do in the consideration of your health claim. To protect your protected health information, however, we require our business associates to appropriately safeguard your information.
- To Workers' Compensation Offices: We may disclose your PHI to the extent authorized by, and to the extent necessary to comply with, laws relating to workers' compensation or other similar programs established by law.
- To Public Health Offices: As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- To Health Oversight Agencies: We may disclose your PHI to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and legal actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and civil rights laws.
- For Health-Related Benefits and Services: We—or our business associates—may contact you or your health care provider to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

- For Food and Drug Administration Activities: We may disclose your PHI to a person or organization required by the Food and Drug Administration to track products or to report adverse effects, product defects or problems, or biological product deviations. Your protected health information may be used to enable product recalls, to make repairs or replacements, or to conduct post-marketing surveillance.
- For Research Studies: We may disclose your PHI to researchers when an institutional review board that has established protocols to ensure the privacy of your protected health information, has approved their research.
- For Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel for activities deemed necessary by military command authorities; or to a foreign military authority if you are a member of that foreign military service. We may also disclose your protected health information to authorized federal officials conducting national security and intelligence activities, including protection of the President.
- For Legal Proceedings: We may disclose your PHI in the course of a judicial or administrative proceeding; in response to an order of a court or administrative tribunal; or in response to a subpoena, discovery request, or other lawful process. Before we release PHI in response to a subpoena, discovery request, or other legal process not accompanied by a court order, we will require certain written assurances from the party seeking the PHI, consistent with the requirements of the HIPAA Privacy Regulations.
- For Law Enforcement: We may disclose your PHI to a law enforcement official as part of certain law enforcement activities.
- Regarding Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the institution or law enforcement official, if the protected health information is necessary for the institution to provide you with health care, to protect the health and safety of you or others, or for the security of the correctional institution.
- For Compliance Verification: We may disclose your PHI to the Secretary of the United States Department of Health and Human Services to investigate or determine our compliance with the federal regulations regarding privacy.
- For Disaster Relief Purposes: We may disclose your protected health information to any authorized public or private entities assisting in disaster relief efforts.

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

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

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

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

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

IV. Specific Uses of Protected Health Information

Our Plan is sponsored and administered by the National Association of Letter Carriers (NALC), AFL-CIO. To be eligible for health benefits under our Plan, you must be a member of the sponsoring organization. We provide NALC and its affiliates with limited information concerning whether individuals are enrolled in this Plan to coordinate with them on the member status and membership requirement and for administrative expense reimbursement. We do not disclose claims-related information to the NALC or its affiliates without your authorization, unless otherwise permitted or required by law.

V. Your Health Information Rights

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

- The right to see and get a copy of your protected health information. To request access to inspect and/or obtain a copy of your PHI, you must submit your request in writing to our Privacy Official, indicating the specific information you want. If you request a copy, we will impose a fee to cover the costs of copying and postage. We may decide to deny access to your protected health information. Depending on the circumstances, that decision to deny access may be reviewable by a licensed health professional that was not involved in the initial denial of access.
- The right to request restrictions on certain uses and disclosures of your PHI. To request a restriction, write to our Privacy Official, indicating what information you want to limit; whether you want to limit use, disclosure, or both; and to whom you want the limits to apply. We are not required to agree to a restriction, but if we do, we will abide by our agreement, unless the restricted information is needed for emergency treatment.
- The right to receive confidential communications of PHI. We will mail our explanation of benefits (EOB) statements and other payment-related materials to the enrollee. However, if you believe disclosure of your protected health information could result in harm to yourself or others, you have the right to request to receive confidential communications of PHI at an alternative address. Send your written request to our Privacy Official at the address listed at the end of this Notice. In the request, you must tell us (1) the address to which we should mail your PHI, and (2) that the disclosure of all or part of your PHI to an address other than the one you provided could endanger you or others. If we can accommodate your request, we will.
- The right to receive an accounting of disclosures of PHI. You may request an accounting of the disclosures made by the Plan or its business associates including the names of persons and organizations that received your personal health information within six years (or less) of the date on which the accounting is requested, but not prior to April 14, 2003. Submit your request in writing to our Privacy Official.

  The listing will not cover disclosures made to carry out treatment, payment or health care operations; disclosures made to you or your personal representative regarding your own PHI; disclosures made to correctional institutions or for law enforcement purposes; or any information that you authorized us to release. The first request within a 12-month period will be free. For additional requests within the 12-month period, we will charge you for the costs of providing the accounting. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time, before any costs are incurred.
- The right to amend the protected health information we have created, if you believe information is wrong or missing, and we agree. If you believe our information about you is incorrect, notify us in writing and we will investigate. Provide us the reason that supports your request. We will correct any errors we find.

We may deny your request for an amendment if it does not include a reason to support your request. Additionally, we may deny your request if you ask us to amend information that 1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; 2) is not part of the health information kept by us; 3) is not part of the information which you would be permitted to inspect and copy; or 4) is accurate and complete.

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

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

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

VI. Our Responsibilities to You

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

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

- We are required to abide by the terms of our Notice.
- We reserve the right to change the terms of our Notice and to make the new Notice provisions effective for all protected health information we maintain.
- If we make a material revision to the content of this notice, we will provide each current member a new notice by mail, within 60 days of the material revision.

VII. To File a Complaint

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

VIII. How to Contact Us

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

The address for our Privacy Official is:

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

IX. Effective Date

The terms of this Notice are in effect as of January 1, 2013.

Section 2. Changes for 2013

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

Program-wide changes

- Removed annual limits on essential health benefits as described in section 1302 of the Affordable Care Act.
- Plans must provide coverage for routine patient costs for items and services furnished in connection with participation in an approved clinical trial.
- Coverage with no cost sharing for additional preventive care and screenings for women provided in comprehensive guidelines adopted by the Health Resources and Service Administration (HRSA).
- Alaska and Kentucky were designated as a Medically Underserved Area in 2012, but will not be designated for 2013. South Carolina is being added as a Medically Underserved Area for the 2013 calendar year.

Changes to this Plan

- Your share of the NALC Postal premium will decrease for Self Only and decrease for Self and Family. (see back cover)
- Your share of the non-Postal premium will decrease for Self Only and decrease for Self and Family. (see back cover)
- We now base our non-PPO Plan allowance on the MultiPlan negotiated rate for providers/facilities who participate in the MultiPlan network. Previously, we based our Plan allowance on the lesser of the 80th percentile of data gathered from health care sources or the MultiPlan negotiated rate. (see page 12)
- We now cover preventive medicine counseling for women as recommended by Health Resources and Services Administration (HRSA). (see page 36)
- We now cover Hepatitis B vaccine for all adults age 19 and older. Previously, we only covered this vaccine when you had medical indications as recommended by the CDC. (see page 34)
- We now cover Measles, Mumps and Rubella (MMR) vaccine for all adults age 19 through 56 and adults age 57 and older with medical indications as recommended by the CDC. Previously, we covered this vaccine for adults age 19 through 49. (see page 34)
- You now pay nothing for a colonoscopy screening with polyp removal—one every 10 years, age 50 and older, when rendered by a PPO provider. Previously, you paid 15%. (see page 35)
- We now cover Human Papillomavirus (HPV) testing for women age 30 and older. Previously, we covered this test once every 3 years for women age 30 through 70. (see page 36)
- You now pay nothing for the initial examination of a newborn child covered under a family enrollment when rendered by a PPO provider. Previously, you paid 15%. (see page 37)
- We now cover alcohol and drug use assessment for children age 11 through 21. (see page 37)
- We now cover developmental screening (including screening for autism) for children under age 3. (see page 38)
- We now cover developmental surveillance and behavioral assessment for children age 21 and younger. (see page 38)
- We now cover one fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides) for children age 18 through 21. We cover this screening for children age 17 and younger with medical indications as recommended by AAP. (see page 38)
- We now cover hearing screening for children age 4 through 10 and all other ages when the child is at high risk for hearing loss as recommended by Bright Futures/AAP. (see page 38)
- We now cover one hemoglobin or hematocrit screening for children age 12 months. (see page 38)
- We now cover lead screening tests for children age 6 and younger with medical indications as recommended by Bright Futures/AAP. (see page 38)

- We now cover one newborn metabolic screening panel, age 2 months and younger. (see page 38)
- We now cover tuberculosis screening for children at high risk as recommended by Bright Futures/AAP, through age 21. (see page 38)
- We now cover vision screening for children age 3 through 18 as recommended by Bright Futures/AAP. Previously, we covered one vision screening for children age 3 through 5. (see page 38)
- You now pay nothing for the rental of breastfeeding equipment when you use a PPO provider. Previously you paid 15% of the Plan allowance. (See page 39)
- We now cover gestational diabetes screening for women who are 24 to 28 weeks pregnant or are at high risk of developing gestational diabetes. (see page 39)
- We now cover lactation support and counseling as recommended by the USPSTF. (see page 40)
- You now pay nothing for hearing aids and the related examination up to the maximum Plan payment of $500 per ear with replacements covered every 3 years. Previously, you paid 15% (after the calendar year deductible) and all charges after we paid $1000 in a lifetime. (see page 43)
- We will now cover one pair of custom functional foot orthotics, including casting, every 5 years when prescribed by a physician. (see page 45)
- We now cover extraspinal chiropractic manipulations. (see page 48)
- You now pay nothing for voluntary female sterilization, surgical placement of implanted contraceptives, insertion of an IUD, and administration of an injectable contraceptive drug when rendered by a PPO provider. Previously, you paid 15%. (see page 52)
- You now pay nothing for outpatient professional anesthesia services for a voluntary female sterilization when rendered by a PPO provider. Previously, you paid 15%. (see page 59)
- You now pay nothing for outpatient services and supplies for a voluntary female sterilization when rendered by a PPO provider. Previously, you paid 15%. (see page 63)
- You now pay the Specialty drug copayment for specialty drugs dispensed in an outpatient hospital setting. Previously, you paid 15% when dispensed or administered by a PPO hospital or 35% when dispensed or administered by a non-PPO hospital. (see page 63)
- You now pay nothing for lab charges related to mental health or substance abuse billed by Quest and LabCorp. Previously, you paid 15%. (see page 70)
- Our brand name drug formulary is open and voluntary. You now pay more for non-formulary brand name drugs. (see page 72)
- You now pay 30% of the cost of formulary brand name drugs purchased at an NALC CareSelect network pharmacy. (see page 75)
- You now pay 45% of the cost of non-formulary brand name drugs purchased at an NALC CareSelect network pharmacy. Previously, you paid 30%. (see page 75)
- You now pay 20% for formulary brand name drugs purchased at an NALC CareSelect network pharmacy when Medicare Part B is primary. (see page 75)
- You now pay 30% for non-formulary brand name drugs purchased at an NALC CareSelect network pharmacy when Medicare Part B is primary. Previously, you paid 20%. (see page 75)
- You now pay $43 for up to a 60-day supply and $65 for a 90-day supply of formulary brand name drugs purchased through our mail order program. (see page 75)
- You now pay $58 for up to a 60-day supply and $80 for a 90-day supply of non-formulary brand name drugs purchased through our mail order program. Previously, you paid $43 for a 60-day supply and $65 for a 90-day supply. (see page 75)
- You now pay $37 for up to a 60-day supply and $55 for a 90-day supply of formulary brand name drugs purchased through our mail order program when Medicare Part B is primary. (see page 75)

- You now pay $52 for up to a 60-day supply and $70 for a 90-day supply of non-formulary brand name drugs purchased through our mail order program when Medicare Part B is primary. Previously, you paid $37 for a 60-day supply and $55 for a 90-day supply. (see page 75)
- You now pay nothing for FDA-approved prescription contraceptive drugs for women. Previously, you paid the applicable cost-share for generic and brand name drugs. (see page 76)
- You now pay nothing for prescription injectable contraceptive drugs, implantable contraceptives, diaphragms or intrauterine devices purchased through our mail order program or at an NALC CareSelect pharmacy. Previously, you paid 15% when performed, administered or dispensed by a PPO provider. (see page 76)
- We now cover prescription oral fluoride supplements for children from age 6 months through 5 years purchased at a network pharmacy. (See page 76)

Clarifications

- We recognize our successful completion of the NCQA HEDIS Compliance Audit by displaying the seal. (see front cover)
- We clarified that we cover routine annual well-women office visits as recommended by the Health Resources and Services Administration (HRSA). (see page 36)
- We clarified that we cover HPV4 immunizations for males age 9 through 21 as recommended by AAP. (see page 37)
- We clarified that we cover dietary counseling for obese adults. (see page 37)
- We clarified that when you are admitted to a hospital for an accidental injury, you receive inpatient hospital benefits. (see page 67)
- Alere™ Health Management now manages the following chronic diseases: chronic heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes, and asthma. (see page 79)
- We clarified that Applied Behavioral Analysis (ABA) therapy is not covered. (see page 83)
- We clarified coverage for genetic counseling and genetic screening. (see page 84)
- Our Plan allowance for facility charges (such as hospital, dialysis facilities, and ambulatory surgical centers) is now based on two and one half times the Medicare reimbursement rate. (see page 101)
- Our Plan allowance for non-PPO medication charges is now based on the suggested wholesale price or an alternative pricing benchmark. Previously, we based our Plan allowance on the average wholesale price. (see page 101)

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

Where you get covered care

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

- **Covered providers**

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

- A licensed doctor of medicine (M.D.) or osteopathy (D.O.); or, for specified services covered by the Plan, a licensed dentist (D.D.S. or D.M.D.), podiatrist (D.P.M.), or chiropractor (D.C.).
- A nurse anesthetist (C.R.N.A.).
- A community mental health organization: A nonprofit organization or agency with a governing or advisory board representative of the community that provides comprehensive, consultative, and emergency services for treatment of mental conditions.
- A qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist, and nursing-school-administered clinic.
- A licensed, certified or registered audiologist.
- A state licensed or certified acupuncturist.
- A licensed, certified or registered respiratory therapist.
- A licensed, certified, or registered dietician or nutritionist.
- A lactation consultant who is licensed as a registered nurse in the United States and is licensed or certified as a lactation consultant by a nationally recognized organization.
- Other providers listed in Section 5. *Benefits*.

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

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

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in the states OPM determines are "medically underserved". For 2013, the states are: Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, South Carolina, and Wyoming. Alaska and Kentucky were designated as a Medically Underserved Area in 2012, but will not be designated for 2013. South Carolina is being added as a Medically Underserved Area for the 2013 calendar year.

- **Covered facilities**

Covered facilities include:

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

- **Freestanding ambulatory facility:** An outpatient facility accredited by the Joint Commission, Accreditation Association of Ambulatory Health Care (AAAHC), American Association for the Accreditation of Ambulatory Surgery Facilities (AAAASF), American Osteopathic Association (AOA), or that has Medicare certification.
- **Hospice:** A facility that 1) provides care to the terminally ill; 2) is licensed or certified by the jurisdiction in which it operates; 3) is supervised by a staff of physicians (M.D. or D.O.) with at least one such physician on call 24 hours a day; 4) provides 24 hours a day nursing services under the direction of a registered nurse (R.N.) and has a full-time administrator; and 5) provides an ongoing quality assurance program.
- **Hospital:** An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission; or 2) any other institution licensed as a hospital, operating under the supervision of a staff of physicians with 24 hours a day registered nursing service, and is primarily engaged in providing general inpatient acute care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities. All these facilities must be provided on its premises or under its control.

  The term "hospital" does not include a convalescent home or extended care facility, or any institution or part thereof which a) is used principally as a convalescent facility, nursing home, or facility for the aged; b) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or c) is operated as a school or residential treatment facility (except as listed in Section 5(e). *Mental health and substance abuse—In-Network Benefits*).
- **Skilled nursing facility (SNF):** A facility eligible for Medicare payment, or a government facility not covered by Medicare, that provides continuous non-custodial inpatient skilled nursing care by a medical staff for post-hospital patients.
- **Treatment facility:** A freestanding facility accredited by the Joint Commission for treatment of substance abuse.

What you must do to get covered care

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

- **Transitional care**

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

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

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

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

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

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

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

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

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

You need prior Plan approval for certain services

The pre-service claim approval processes for inpatient hospital admissions (called precertification) and for other services, are detailed in this Section. A **pre-service claim** is any claim, in whole or in part, that requires approval from us in advance of obtaining medical care or services. In other words, a pre-service claim for benefits (1) requires precertification, preauthorization, or prior approval and (2) will result in a reduction of benefits if you do not obtain precertification, preauthorization, or prior approval.

- **Inpatient hospital admission**

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 requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether they have contacted us.

- **Warning**

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

- **How to precertify an admission**

- You, your representative, your physician, or your hospital must call us at 1-877-220-NALC (6252) prior to admission, unless your admission is related to a mental health and substance abuse condition. In that case, call 1-877-468-1016.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Member identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization, and proposed treatment, or surgery;
  - Name and phone number of admitting physician;
  - Name of hospital or facility; and
  - Number of planned days of confinement.
- We will then tell the physician and/or hospital the number of approved inpatient days and send written confirmation of our decision to you, your physician, and the hospital.

- **Emergency inpatient admission**

  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. If you do not telephone the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admissions* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

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

- **If your hospital stay needs to be extended**

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

- **What happens when you do not follow the precertification rules**

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

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

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

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

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

- **Exceptions**

  You do not need precertification in these cases:

  - You are admitted to a hospital outside the United States.
  - You have another group health insurance policy that is the primary payor for the hospital stay.
  - Medicare Part A is the primary payor for the hospital stay. Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payor and you **do** need precertification.

- **Precertification of radiology/imaging services**

  The following outpatient radiology/imaging services need to be precertified:

  - CT/CAT – Computerized Axial Tomography;
  - MRI – Magnetic Resonance Imaging;
  - MRA – Magnetic Resonance Angiography;
  - NC – Nuclear Cardiac Imaging Studies; and
  - PET – Positron Emission Tomography.

- **How to precertify radiology/imaging services**

  For outpatient CT/CAT, MRI, MRA, NC, or PET scans, your provider, or facility must call 1-877-220-NALC (6252) before scheduling the procedure.

- **Exceptions**

  You do not need precertification in these cases:

  - You have another health insurance that is the primary payor including Medicare Part A & B or Part B only;
  - The procedure is performed outside the United States;
  - You are admitted to a hospital; or
  - The procedure is performed as an emergency.

- **Warning**

  We may deny benefits if you fail to precertify these radiology procedures.

Precertification, prior authorization, or prior approval for other services

- **Other services**

  Other services require precertification, preauthorization, or prior approval.

  - All specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy 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 policy—including Medicare—that is your primary payor.

- **Non-urgent care claims**

  For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim.

  If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

  If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

  If you have an **urgent care claim** (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-888-636-NALC (6252). You may also call OPM's Health Insurance 2 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, then call us at 703-729-4677 or 1-888-636-NALC (6252). If it is determined that your claim is an urgent care claim, we will hasten our review (if we have not yet responded to your claim).

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have **a post-service** claim and must follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

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

Cost-sharing

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

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 $350 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 and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible. Your copayments, excluding prescription drugs, **do** count toward your out-of-pocket maximum.

- The calendar year deductible is $300 per person ($600 per family).

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 ($300) 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 does not begin until you have met your calendar year 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 $49.00 (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 contracts that Cigna HealthCare has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 1-888-636-NALC (6252).

Differences between our allowance and the bill

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

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

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your copayment, deductible, and coinsurance. Here is an example about coinsurance: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just 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, the physician can bill you for the $50 difference between our allowance and his/her bill.

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

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	$150	$150
Our allowance	We set it at: 100	We set it at: 100
We pay	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 subject to a deductible, coinsurance and copayment (including mental health and substance abuse care), we pay 100% of the Plan allowance for the remainder of the calendar year after your cost-share totals:

- $5,000 per person or family for services of PPO providers/facilities.
- $7,000 per person or family for services of PPO and non-PPO providers/facilities, combined.

- Coinsurance amounts for prescription drugs dispensed by an NALC Preferred or NALC CareSelect Network pharmacy and mail order copayment amounts for specialty drugs (see Section 5(f). *Prescription drug benefits*) count toward a $4,000 per person or family annual retail prescription out-of-pocket maximum excluding the following amounts:
  - The 45% coinsurance for prescriptions purchased at a non-network pharmacy or for additional fills at an NALC CareSelect pharmacy.
  - Any associated costs when you purchase medications in excess of the Plan's dispensing limitations.
  - The difference in cost between a brand name and a generic drug when you elect to purchase the brand name, and a generic drug is available, and your physician has not specified "Dispense as Written".

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

- Expenses in excess of the Plan allowance or maximum benefit limitations
- 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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

(See page 18 for how our benefits changed this year and page 108 for a benefits summary.)

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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 calendar year deductible 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 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 may **not** all be preferred providers. If they are not, they will be paid as non-PPO providers. However, we will process charges for radiology, pathology, the administration of anesthesia and the emergency room visit billed by non-PPO providers at the PPO benefit level, based on Plan allowance, if the services are rendered at a PPO hospital or PPO ambulatory surgical center.
- Be sure to read Section 4. *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR CERTAIN OUTPATIENT RADIOLOGY/ IMAGING PROCEDURES.** FAILURE TO DO SO MAY RESULT IN A DENIAL OF BENEFITS. Please refer to precertification information in Section 3 to be sure which procedures require precertification.

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

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After calendar year deductible
Diagnostic and treatment services (cont.)	
Not covered: • *Routine eye and hearing examinations (except as listed in* Preventive care, children *and* Hearing services... *in this section)* • *Nonsurgical treatment for weight reduction or obesity (except as listed in* Educational classes and programs *in this section)*	*All charges*
Lab, x-ray and other diagnostic tests	
Tests and their interpretation, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram (EKG) • Electroencephalogram (EEG) • Bone density study • CT Scans/MRI/MRA/NC/PET (Outpatient requires precertification - See Section 3) Note: When tests are performed during an inpatient confinement, no deductible applies.	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
If LabCorp or Quest Diagnostics performs your covered lab services, you will have no out-of-pocket expense and you will not have to file a claim. Ask your doctor to use LabCorp or Quest Diagnostics for lab processing. To find a location near you, call 1-877-220-NALC (6252), or visit our Web site at www.nalc.org/depart/hbp.	Nothing (No deductible)
Not covered: Routine tests, except listed under Preventive care, adult *in this section.*	*All charges*
Preventive care, adult	
Routine examinations, limited to: • Routine physical exam—one annually, age 22 or older • Initial office visit associated with a covered routine sigmoidoscopy or colonoscopy screening test Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC), limited to:	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay After calendar year deductible
Preventive care, adult (cont.)	
• Haemophilus influenza type b (Hib)—one, age 19 and older with medical indications as recommended by the CDC (except as provided for under *Preventive care, children* in this section) • Hepatitis A vaccine—adults age 19 and older with medical indications as recommended by the CDC • Hepatitis B vaccine—adults age 19 and older • Herpes Zoster (shingles) vaccine—adults age 60 and older • Human Papillomavirus (HPV) vaccine—adult women age 26 and younger • Human Papillomavirus (HPV4) vaccine—adult men age 26 and younger • Influenza vaccine—one per flu season • Measles, Mumps, Rubella (MMR) - Age 19 through 56 (except as provided for under *Preventive care, children* in this section) - Age 57 and older with medical indications as recommended by the CDC • Meningococcal vaccine—adults age 19 and older with medical indications as recommended by the CDC (except as provided for under *Preventive care, children* in this section) • Pneumococcal vaccine— - Age 19 through 64 with medical indications as recommended by the CDC - Age 65 and older • Tetanus-diphtheria (Td) booster—one every 10 years, age 19 and older (except as provided for under *Preventive care, children* in this section) • Tetanus-diphtheria, pertussis (Tdap) booster—one, age 19 and older (except as provided for under *Preventive care, children* in this section) • Varicella (chickenpox) vaccine—adults age 19 and older Note: Herpes Zoster (shingles) vaccine is available at local Preferred Network or NALC CareSelect Network pharmacies. Call us at 703-729-4677 or 1-888-636-NALC (6252) prior to purchasing this vaccine at your local pharmacy.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay After calendar year deductible
Preventive care, adult (cont.)	
Note: When the NALC Health Benefit Plan is the primary payor for medical expenses, the seasonal flu vaccine and adult pneumococcal vaccine will be paid in full when administered by a pharmacy that participates in the NALC Flu and Pneumococcal Vaccine Administration Network. A full list of participating pharmacies is available at www.pharmacyshots.com/vaccine_network_01.pdf or call Caremark Customer Service at 1-800-933-NALC (6252) to locate a local participating pharmacy. Routine screenings, limited to: • Abdominal aortic aneurysm screening by ultrasonography—one in a lifetime, for men age 65 through 75 with smoking history • Basic or comprehensive metabolic panel blood test—one annually • BRCA testing and genetic counseling for women with increased risk of breast or ovarian cancer as recommended by the U.S. Preventive Services Task Force (USPSTF) • Chest x-ray—one annually • Chlamydial infection test • Colorectal cancer screening, including: - Fecal occult blood test—one annually, age 40 and older - Double Contrast Barium Enema (DCBE)—one every five years, age 50 and older - Sigmoidoscopy screening—one every five years, age 50 and older • Colonoscopy screening (with or without polyp removal)—one every 10 years, age 50 and older • Complete Blood Count (CBC)—one annually • Diabetes screening to include: - Two fasting blood sugar tests every three years - One hemoglobin A1C test and one 2-hour blood sugar test every three years for adults with medical indications as recommended by the U.S. Preventive Services Task Force (USPSTF) • Electrocardiogram (ECG/EKG)—one annually • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglycerides)—one every five years, age 20 and older • General health panel blood test—one annually • Gonorrhea screening limited to: - Women age 25 and younger	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay After calendar year deductible
Preventive care, adult (cont.)	
- Women at increased risk as recommended by the U.S. Preventive Services Task Force (USPSTF) • High blood pressure screening • Human Immunodeficiency Virus (HIV)—one annually • Mammogram—for women age 35 and older, as follows: - Age 35 through 39—one during this five year period - Age 40 and older—one every calendar year • Osteoporosis screening limited to: - Women age 40 - 64 at increased risk as recommended by the U.S. Preventive Services Task Force (USPSTF) - Women age 65 and older • Prostate Specific Antigen (PSA) test—one annually for men, age 40 and older • Syphilis screening for adults at increased risk as recommended by the U.S. Preventive Services Task Force (USPSTF) • Total blood cholesterol—one every three years • Urinalysis—one annually • Well woman—one annually; including: - Routine pap test - Human papillomavirus testing for women age 30 and older - Counseling for sexually transmitted infections on an annual basis. - Counseling and screening for human immunodeficiency virus on an annual basis for sexually active women. - Contraception counseling for women with reproductive capability. - Screening and counseling for interpersonal and domestic violence. Note: To reduce your out-of-pocket costs for laboratory services use LabCorp or Quest Diagnostics, see *Lab, x-ray, and other diagnostic tests* in this section. Preventive medicine counseling by a covered primary care provider as recommended by the U.S. Preventive Services Task Force (USPSTF), limited to: • Alcohol abuse • Aspirin use for the prevention of cardiovascular disease	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay After calendar year deductible
Preventive care, adult (cont.)	
• Breast cancer chemoprevention • Depression • Obesity (includes dietary counseling for adults at higher risk for chronic disease) • Sexually transmitted infections • Tobacco use Note: See Section 5(a). *Educational classes and programs* for more information on tobacco cessation and see Section 5(f). *Prescription drug benefits* for prescription medications used for tobacco cessation.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Routine lab tests, except listed under Preventive care, adult *in this section.*	*All charges*
Preventive care, children	
• Examinations, limited to: - Initial examination of a newborn child covered under a family enrollment - Well-child care—routine examinations through age 2 - Routine physical exam (including camp, school, and sports physicals)—one annually, age 3 through 21 - Examinations done on the day of covered immunizations, age 3 through 21 • Childhood immunizations through age 21, limited to: - Immunizations recommended by the American Academy of Pediatrics (AAP) - Human Papillomavirus (HPV4) vaccine—males age 9 through 21, as recommended by the AAP - Meningococcal immunization—as recommended by the AAP Note: When the NALC Health Benefit Plan is the primary payor for medical expenses, the seasonal flu vaccine and pediatric pneumococcal vaccine will be paid in full when administered by a pharmacy that participates in the NALC Flu and Pneumococcal Vaccine Administration Network. A full list of participating pharmacies is available at www.pharmacyshots.com/vaccine_network_01.pdf or call Caremark Customer Service at 1-800-933-NALC (6252) to locate a local participating pharmacy. Routine screenings, limited to: • Alcohol and drug use assessment as recommended by Bright Futures/AAP—age 11 through 21 • Chlamydial infection test	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, children - continued on next page

Benefit Description	You pay After calendar year deductible
Preventive care, children (cont.)	
• Developmental screening (including screening for autism) as recommended by Bright Futures/AAP – through age 3 • Developmental surveillance and behavioral assessment as recommended by Bright Futures/AAP —age 21 and younger • Fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides): - One, age 18 through 21 - Age 17 and younger with medical indications as recommended by Bright Futures/AAP • Gonorrhea screening—as recommended by the U.S. Preventive Services Task Force (USPSTF) • Hearing screening: - Age 4 through 10 - For those at high risk as recommended by Bright Futures/AAP, through age 21 • Hemoglobin/hematocrit - one, at age 12 months - one annually, for females age 11 through 21 • High blood pressure screening • Human Immunodeficiency Virus (HIV)—as recommended by the U.S. Preventive Services Task Force (USPSTF)—one annually • Lead screening test—age 6 and younger with medical indications as recommended by Bright Futures/AAP • Newborn metabolic screening panel—one, age 2 months and younger • Newborn screening hearing test—one in a lifetime • Newborn screening test for congenital hypothyroidism, phenylketonuria (PKU) and sickle cell—one in a lifetime • Pap test • Tuberculosis screening—for those at high risk as recommended by Bright Futures/AAP, through age 21 • Urinalysis—one annually, age 5 through 21 • Vision screening for amblyopia or its risk factors (limited to: strabismus, astigmatism, anisometropia, and hyperopia) as recommended by the U.S. Preventive Services Task Force (USPSTF)—one annually age 3 through 5 • Vision screening – age 6 through 18 as recommended by Bright Futures/AAP	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, children - continued on next page

Benefit Description	You pay After calendar year deductible
Preventive care, children (cont.)	
Note: For the coverage of the initial newborn exam see *Diagnostic and treatment services* in this section. Preventive medicine counseling by a covered primary care provider as recommended by the U.S. Preventive Services Task Force (USPSTF), limited to: • Anemia • Dental cavities • Major depressive disorder • Obesity • Sexually transmitted infections • Tobacco use	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Routine hearing testing, except as listed in* Preventive care, children *and* Hearing services... *in this section* • *Hearing aid and examination, except as listed in* Hearing services... *in this section* • *Routine lab tests, except as listed in* Preventive care, children *in this section*	*All charges*
Maternity care	
Complete maternity (obstetrical) care, limited to: • Routine prenatal visits • Delivery • Routine postnatal visits • Amniocentesis • Anesthesia related to delivery or amniocentesis • Group B streptococcus infection screening • Sonograms • Fetal monitoring • Rental of breastfeeding equipment Screening tests as recommended by the USPSTF for pregnant women, limited to: • Gestational diabetes • Hepatitis B • Iron deficiency anemia • Rh screening • Syphilis • Urine culture for bacteria Preventive medicine counseling for breastfeeding as recommended by the U.S. Preventive Services Task Force (USPSTF) for pregnant women, limited to:	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Maternity care - continued on next page

Benefit Description	You pay After calendar year deductible
Maternity care (cont.)	
• Lactation support and counseling	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Other tests medically indicated for the unborn child or as part of the maternity care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see Section 3. *How to get approval for…* for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • The circumcision charge for an infant covered under a Self and Family enrollment is payable under surgical benefits. See Section 5(b). *Surgical procedures*. • We pay hospitalization, anesthesia, and surgeon services for non-maternity care the same as for illness and injury. • To reduce your out-of-pocket costs for laboratory services use LabCorp or Quest Diagnostics, see *Lab, x-ray, and other diagnostic tests* in this section.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Family planning	
Voluntary family planning services, limited to: • Voluntary female sterilization • Surgical placement of implanted contraceptives • Insertion of intrauterine devices (IUDs) • Administration of an injectable contraceptive drug (such as Depo provera) Note: Outpatient facility related to voluntary female sterilization is payable under outpatient hospital benefit. See Section 5(c). *Outpatient hospital*. For anesthesia related to voluntary female sterilization, see Section 5 (b). *Anesthesia*.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Family planning - continued on next page

Benefit Description	You pay After calendar year deductible
Family planning (cont.)	
Note: We cover oral contraceptives, injectable contraceptive drugs (such as Depo provera), diaphragms, intrauterine devices and implanted contraceptives, (such as Implanon) only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits.*	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Vasectomy (see Section 5(b). *Surgical procedures*)	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
Not covered: Reversal of voluntary surgical sterilization, genetic counseling	*All charges*
Infertility services	
Diagnosis and treatment of infertility, except as shown in *Not covered.* Limited benefits: We pay a $2500 calendar year maximum per person to diagnose or treat infertility.	PPO: 15% of the Plan allowance and all charges after we pay $2500 in a calendar year Non-PPO: 30% of the Plan allowance and all charges after we pay $2500 in a calendar year
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures such as:* - *Artificial insemination* - *In vitro fertilization* - *Embryo transfer and gamete intrafallopian transfer (GIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Prescription drugs for infertility*	*All charges*
Allergy care	
• Testing • Treatment, except for allergy injections • Allergy serum	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Allergy injections	PPO: $5 copayment each (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Provocative food testing and sublingual allergy desensitization* • *Environmental control units, such as air conditioners, purifiers, humidifiers, and dehumidifiers*	*All charges*

Benefit Description	You pay After calendar year deductible
Treatment therapies	
• Intravenous (IV)/Infusion Therapy—Home IV and antibiotic therapy • Respiratory and inhalation therapies • Growth hormone therapy (GHT) Note: Specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs, available through Caremark Specialty Pharmacy Services are covered only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits.* Note: Prior approval is required for all specialty drugs used to treat chronic medical conditions. See instructions for approval in Section 5(f). *Prescription drug benefits—These are the dispensing limitations.* • Dialysis—hemodialysis and peritoneal dialysis • Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b). *Organ/tissue transplants.* Note: Oral chemotherapy drugs available through Caremark are covered only under the Prescription drug benefit. Section 5(f). *Prescription drug benefits—These are the dispensing limitations.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Chelation therapy, except as treatment for acute arsenic, gold, lead, or mercury poisoning* • *Prolotherapy*	*All charges*
Physical, occupational, and speech therapies	
• A combined total of 75 visits per calendar year for treatment provided by a licensed registered therapist or physician for the following: - Physical therapy - Occupational therapy - Speech therapy Therapy is covered when the attending physician: • Orders the care; • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed.	PPO: $20 copayment per visit (no deductible) and all charges after 75 visit limit Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after 75 visit limit Note: When physical, occupational, and/or speech therapy are performed on the same day, a separate $20 copayment applies to each type of therapy billed.

Physical, occupational, and speech therapies - continued on next page

Benefit Description	You pay After calendar year deductible
Physical, occupational, and speech therapies (cont.)	
Note: We cover physical and occupational therapy only to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Note: For accidental injuries, see Section 5(d). *Emergency services/accidents*. Note: For therapies performed on the same day as outpatient surgery, see Section 5(c). *Outpatient hospital or ambulatory surgical center*. Note: Physical therapy by a chiropractor is covered when the service performed is within the scope of his/her license.	PPO: $20 copayment per visit (no deductible) and all charges after 75 visit limit Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after 75 visit limit Note: When physical, occupational, and/or speech therapy are performed on the same day, a separate $20 copayment applies to each type of therapy billed.
• Cardiac rehabilitation therapy	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: • *Exercise programs* • *Maintenance therapy that maintains a functional status or prevents decline in function*	*All charges*
Hearing services (testing, treatment, and supplies)	
• For treatment (excluding hearing aids) related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • First hearing aid and examination, limited to services necessitated by accidental injury	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Hearing aid and related examination for neurosensory hearing loss limited to a maximum Plan payment of $500 per ear with replacements covered every 3 years.	PPO: Nothing up to the Plan limit Non-PPO: Nothing up to the Plan limit and the difference, if any, between our allowance and the billed amount
Not covered: • *Routine hearing testing (such as testing for routine hearing loss as a result of aging), except as listed in* Preventive care, children *and* Hearing services... *in this section* • *Hearing aid and examination, except as described above* • *Auditory device except as described above*	*All charges*

Benefit Description	You pay After calendar year deductible
Vision services (testing, treatment, and supplies)	
• Office visit for 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
• 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 • Tests and their interpretations for covered diagnoses, such as: - Fundus photography - Visual field - Corneal pachymetry Note: We only cover the standard intraocular lens prosthesis, such as for cataract surgery. Note: For childhood preventive vision screenings see *Preventive care, children* in this section. Note: See Section 5(h). *Healthy Rewards Program* for discounts available for vision care.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them, except as described above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Refractions*	*All charges*
Foot care	
• Nonsurgical routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Surgical procedures for routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes • Open cutting, such as the removal of bunions or bone spurs • Extracorporeal shock wave treatment (when symptoms have existed for at least 6 months and other standard methods of treatment have been unsuccessful)	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
Not covered:	*All charges*

Foot care - continued on next page

Benefit Description	You pay After calendar year deductible
Foot care (cont.)	
• *Cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained, or flat feet; bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotics (shoe inserts) except as listed under* Orthopedic and prosthetic devices *in this section* • *Arch supports, heel pads, and heel cups* • *Orthopedic and corrective shoes*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Custom-made durable braces for legs, arms, neck, and back • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b). *Surgical procedures.* For information on the hospital and/or ambulatory surgery center benefits, see Section 5 (c). *Services provided by a hospital or other facility, and ambulance services.* Note: Internal prosthetic devices billed by the hospital are paid as hospital benefits. See Section 5(c). *Services provided by a hospital or other facility, and ambulance services.* Note: We only cover the standard intraocular lens prosthesis, such as for cataract surgery.	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
• One pair of custom functional foot orthotics, including casting, every 5 years when prescribed by a physician (with a maximum Plan payment of $400).	PPO: 15% of the Plan allowance and all charges after we pay $400 Non-PPO: 30% of the Plan allowance and all charges after we pay $400
• Repair of existing custom functional foot orthotics (with a maximum Plan payment of $100 every 3 years)	PPO: 15% of the Plan allowance and all charges after we pay $100

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After calendar year deductible
Orthopedic and prosthetic devices (cont.)	
	Non-PPO: 30% of the Plan allowance and all charges after we pay $100
Not covered: • *Wigs (cranial prosthetics)* • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics (shoe inserts) except as listed under* Orthopedic and prosthetic devices *in this section* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Bionic prosthetics (including microprocessor-controlled prosthetics)* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. Note: Call us at 703-729-4677 or 1-888-636-NALC (6252) as soon as your physician prescribes equipment or supplies. The Plan requires a letter of medical necessity, or a copy of the prescription, from the prescribing physician which details the medical necessity to consider charges for the purchase or rental of DME. We cover rental or purchase (at our option) including repair and adjustment of durable medical equipment, such as: • Oxygen and oxygen apparatus • Dialysis equipment • Hospital beds	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After calendar year deductible
Durable medical equipment (DME) (cont.)	
• Wheelchairs • Crutches, canes, and walkers Note: We limit the Plan allowance for our DME rental benefit to an amount no greater than what we would have considered if the equipment had been purchased. We also cover supplies, such as: • Insulin and diabetic supplies • Needles and syringes for covered injectables • Ostomy and catheter supplies	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *DME replacements (including rental) provided less than 3 years after the last one we covered* • *Sun or heat lamps, whirlpool baths, saunas, and similar household equipment* • *Safety, convenience, and exercise equipment* • *Communication equipment including computer "story boards" or "light talkers"* • *Enhanced vision systems, computer switch boards, or environmental control units* • *Heating pads, air conditioners, purifiers, and humidifiers* • *Stair climbing equipment, stair glides, ramps, and elevators* • *Modifications or alterations to vehicles or households* • *Equipment or devices, such as iBOT Mobility System that allow increased mobility, beyond what is provided by standard features of DME* • *Other items (such as wigs) that do not meet the criteria 1 thru 6 on page 46*	*All charges*
Home health services	
Home nursing care for 2 hours per day up to 50 days per calendar year when: • a registered nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.) provides the services; • the attending physician orders the care; • the physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • the physician indicates the length of time the services are needed.	PPO: 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:	*All charges*

Home health services - continued on next page

Benefit Description	You pay After calendar year deductible
Home health services (cont.)	
• *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*
Chiropractic	
Limited to: • Initial set of spinal x-rays • 20 spinal or extraspinal manipulations per calendar year Note: The above services rendered by a chiropractor in medically underserved areas are subject to these limitations. Benefits may be available for other covered services, such as physical therapy, you receive from a chiropractor. See *Physical, occupational, and speech therapies*, in this section. Note: When spinal and extraspinal manipulations are performed on the same day, each manipulation applies to the calendar year maximum.	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
Limited to: • Initial office visit or consultation • 20 office visits per calendar year when rendered on the same day as a covered spinal or extraspinal manipulation	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
Not covered: Any treatment not specifically listed as covered	*All charges*
Alternative treatments	
Limited to: • Acupuncture, by a doctor of medicine or osteopathy, or a state licensed or certified acupuncturist. Benefits are limited to 15 acupuncture visits per person per calendar year. Note: In medically underserved areas, we may cover services of alternative treatment providers. See Section 3. *Covered providers*.	PPO: 15% of the Plan allowance and all charges after 15 visit limit Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after 15 visit limit
Not covered: • *Services performed by an acupuncturist who is not licensed or certified, even if the state where services are performed does not require acupuncturists to be licensed or certified* • *Naturopathic services* • *Cosmetic acupuncture*	*All charges*

Benefit Description	You pay After calendar year deductible
Educational classes and programs	
Coverage includes: • A voluntary tobacco cessation program offered by the Plan which includes: - Five professional 30 minute telephonic counseling sessions per quit attempt, limited to two quit attempts per year - Online tools - Over-the-counter nicotine replacement therapy - Toll-free phone access to Tobacco Coaches for one year For more information on the program or to join, visit www.quitnow.net/nalc or call 1-866-QUIT-4-LIFE (1-866-784-8454). Note: For group and individual counseling for tobacco cessation, see Preventive care, adult in this section. Note: FDA-approved prescription medications and over-the-counter medications (when purchased with a prescription) for tobacco cessation are covered only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits*.	Nothing for services obtained through the tobacco cessation program offered by the Plan (No deductible)
• Educational classes and nutritional therapy for self-management of diabetes, hyperlipidemia, hypertension, and obesity when: - Prescribed by the attending physician, and - Administered by a covered provider, such as a registered nurse or a licensed or registered dietician/nutritionist. Note: To join our Weight Management Program, see Section 5(h). *Special features*.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

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

Important 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 (d), the calendar year deductible applies to only a few benefits. In that case, we say "(calendar year deductible applies)." The calendar year deductible is $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 may **not** all be preferred providers. If they are not, they will be paid as non-PPO providers. However, we will process charges for radiology, pathology, the administration of anesthesia and the emergency room visit billed by non-PPO providers at the PPO benefit level, based on Plan allowance, if the services are rendered at a PPO hospital or PPO ambulatory surgical center.
- Be sure to read Section 4. *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c). *Services provided by a hospital or other facility, and ambulance services*, for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL FOR ORGAN/TISSUE TRANSPLANTS**. See Section 5(b). *Organ/tissue transplants*.

Benefit Description	You pay
Note: The calendar year deductible applies ONLY when we say, "(calendar year deductible applies)."	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies • Insertion of internal prosthetic devices. See Section 5(a). *Orthopedic and prosthetic devices*, for device coverage information. • Vasectomy • Debridement of burns	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 (calendar year deductible applies)

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• Surgical treatment of morbid obesity (bariatric surgery) is covered when: 1. Clinical records support a body mass index (BMI) of 40 or greater, or 35 or greater with high-risk comorbid conditions such as serious cardiopulmonary problems or severe diabetes mellitus. 2. Diagnosis of morbid obesity for a period of two years prior to surgery. 3. There is no treatable metabolic cause for the obesity. 4. The patient has participated in a physician-supervised weight-loss program, of at least six months duration, that includes dietary therapy, physical activity and behavior modification. This physician-supervised program must be documented in the medical records. Surgery must occur within six months of completion of the physician-supervised weight-loss program. 5. 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. 6. The patient is age 18 or older. 7. A psychological evaluation has been completed and the patient has been recommended for bariatric surgery. 8. Patient has not smoked in the six months prior to surgery. 9. Patient has not been treated for substance abuse for one year prior to surgery. 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. Note: The Plan allowance for an assistant surgeon will not exceed 25% of our allowance for the surgeon. Note: When a surgery requires two primary surgeons (co-surgeons), the Plan allowance for each surgeon will not exceed 62.5% of our allowance for a single surgeon to perform the same procedure(s).	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 (calendar year deductible applies)

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
Note: Simple repair of a laceration (stitches) and immobilization by casting, splinting, or strapping of a sprain, strain, or fracture, will be considered under this benefit when services are rendered after 72 hours of the accident. Note: We only cover the standard intraocular lens prosthesis for cataract surgery. Note: **Initial** inpatient (non-elective) surgery rendered by a non-PPO surgeon for the surgical treatment of appendicitis, brain aneurysms, burns, or gunshot wounds will be paid at the PPO benefit level.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
• Voluntary female sterilization • Surgical placement of implanted contraceptives • Insertion of intrauterine devices (IUDs) Note: We cover intrauterine devices and implanted contraceptives, (such as Implanon) only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits.*	PPO: Nothing Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone), except as listed in Section 5(g).* Dental benefits • *Cosmetic surgery, except for repair of accidental injury if repair is initiated within six months after an accident; correction of a congenital anomaly; or breast reconstruction following a mastectomy* • *Radial keratotomy and other refractive surgery* • *Procedures performed through the same incision deemed incidental to the total surgery, such as appendectomy, lysis of adhesion, puncture of ovarian cyst* • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standby surgeons are medically necessary* • *Cutting, trimming, or removal of corns, calluses, or the free edge of toenails; and similar routine treatment of conditions of the foot, except as listed under Section 5(a).* Foot care	*All charges*

Benefit Description	You pay
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance; and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a congenital anomaly (condition that existed at or from birth and is a significant deviation from the common form or norm). Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedemas Note: Congenital anomaly does not include conditions related to teeth or intra-oral structures supporting the teeth. Note: We cover internal and external breast prostheses, surgical bras and replacements. See Section 5(a). *Orthopedic and prosthetic devices*, and Section 5(c). *Inpatient hospital.* Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Cosmetic surgery—any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury if repair is initiated within six months* • *Injections of silicone, collagens, and similar substances* • *Surgeries related to sex transformation or sexual dysfunction*	*All charges*

Benefit Description	You pay
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures • Removal of impacted teeth that are not completely erupted (bony, partial bony and soft tissue impaction)	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 (calendar year deductible applies)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except as listed in Section 5(g).* Dental benefits *and* Oral and maxillofacial surgery *in this section*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* in Section 3 for prior authorization procedures. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung single/bilateral/lobar • Pancreas	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® 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 (calendar year deductible applies)
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. See *Other services* in Section 3 for prior authorization procedures.	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® PPO: 15% of the Plan allowance

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
• Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® 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 (calendar year deductible applies)
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteoporosis - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® 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 (calendar year deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® 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 (calendar year deductible applies)
Blood or marrow stem cell transplants covered only in a National Cancer Institute (NCI) or National Institutes of Health (NIH) approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols limited to: • Autologous transplants for: - Breast cancer - Epithelial ovarian cancer - Childhood rhabdomyosarcoma - Advanced Ewing sarcoma - Advanced childhood kidney cancers - Mantle Cell (non-Hodgkin's lymphoma) Note: If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. See *Other services* in Section 3 for prior authorization procedures. • Allogeneic transplants for: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Neuroblastoma Note: If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® 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 (calendar year deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
Cigna ***Life***SOURCE Transplant Network®—The Plan participates in the Cigna ***Life***SOURCE Transplant Network®. Before your initial evaluation as a potential candidate for a transplant procedure, you or your physician must contact Cigna HealthCare at 1-800-668-9682 and speak to a referral specialist in the Comprehensive Transplant Case Management Unit. You will be given information about this program including a list of participating providers. Charges for services performed by a Cigna ***Life***SOURCE Transplant Network® provider, whether incurred by the recipient or donor are paid at 85% including inpatient hospital, surgical and any other medical expenses. Participants in the program must obtain prior approval from the Plan to receive limited travel and lodging benefits.	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®
Limited Benefits—If you do not obtain prior approval or do not use a designated facility, or if we are not the primary payor, we pay a maximum of $100,000 for each listed transplant (kidney limit, $50,000), for these combined expenses: pre-transplant evaluation; organ procurement; and inpatient hospital, surgical and medical expenses. We pay benefits according to the appropriate benefit section, such as Section 5(c). *Inpatient hospital*, and *Surgical procedures* in this section. The limitation applies to expenses incurred by either the recipient or donor. Note: Some transplants listed may not be covered through the Cigna ***Life***SOURCE Transplant Network®. Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.	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 (calendar year deductible applies)
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Travel and lodging expenses, except when approved by the Plan* • *Implants of artificial organs* • *Transplants and related services and supplies not listed as covered*	*All charges*

Benefit Description	You pay
Anesthesia	
Professional services provided in: • Hospital (inpatient) Note: If surgical services (including maternity) are rendered at a PPO hospital, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level.	PPO: Nothing when services are related to the delivery of a newborn. 15% of the Plan allowance for anesthesia services for all other conditions. Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Professional services provided in: • Hospital outpatient department • Ambulatory surgical center • Office • Other outpatient facility Note: If surgical services are rendered at a PPO hospital or ambulatory surgical center, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level.	PPO: Nothing when services are related to the delivery of a newborn. 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Professional services provided for: • Voluntary female sterilization	PPO: Nothing 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 calendar year deductible is $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 may **not** all be preferred providers. If they are not, they will be paid as non-PPO providers. However, we will process charges for radiology, pathology, the administration of anesthesia and the emergency room visit billed by non-PPO providers at the PPO benefit level, based on Plan allowance, if the services are rendered at a PPO hospital or PPO ambulatory surgical center.
- Be sure to read Section 4. *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Charges billed by a facility for implantable devices, surgical hardware, etc., are subject to the Plan allowance which is based on the provider's cost plus a reasonable handling fee. The manufacturer's invoice that includes a description and cost of the implantable device or hardware may be required in order to determine benefits payable.
- The amounts listed below are for charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. See Sections 5(a) or (b) for costs associated with the professional charge (i.e., physicians, etc.).
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • Birthing room • General nursing care • Meals and special diets Note: We cover a private room only when you must be isolated to prevent contagion. Otherwise, we pay the hospital's average charge for semiprivate accommodations. If the hospital has private rooms only, we base our payment on the average semiprivate rate of the most comparable hospital in the area.	PPO: Nothing when services are related to the delivery of a newborn. $200 copayment per admission for all other admissions. Non-PPO: $350 copayment per admission and 30% of the Plan allowance 15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
Note: When the non-PPO hospital bills a flat rate, we prorate the charge as follows: 30% room and board and 70% other charges. Note: When room and board charges are billed by a hospital, inpatient benefits apply. When room and board charges are not billed, see *Outpatient hospital or ambulatory surgical center* in this section.	PPO: Nothing when services are related to the delivery of a newborn. $200 copayment per admission for all other admissions. Non-PPO: $350 copayment per admission and 30% of the Plan allowance 15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Preadmission testing (within 7 days of admission), limited to: - Chest x-rays - Electrocardiograms - Urinalysis - Blood work • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Internal prostheses • Professional ambulance service to the nearest hospital equipped to handle your condition • Occupational, physical, and speech therapy Note: We base payment on who bills for the services or supplies. For example, when the hospital bills for its nurse anesthetist's services, we pay hospital benefits and when the anesthesiologist bills, we pay anesthesia benefits. See Section 5(b). *Surgical procedures*. Note: We cover your admission for dental procedures only when you have a nondental physical impairment that makes admission necessary to safeguard your health. We do not cover the dental procedures or the anesthesia service when billed by the anesthesiologist. Note: We cover your admission for inpatient foot treatment even if no other benefits are payable. Note: Diagnostic tests, such as magnetic resonance imaging, throat cultures, or similar studies are not considered as preadmission testing.	PPO: Nothing when services are related to the delivery of a newborn. $200 copayment per admission for all other admissions. Non-PPO: $350 copayment per admission and 30% of the Plan allowance 15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
Take-home items: • Medical supplies, appliances, and equipment; and any covered items billed by a hospital for use at home	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance (calendar year deductible applies)
Not covered: • *Any part of a hospital admission that is not medically necessary (See Section 10.* Definitions . . . Medical Necessity*), such as subacute care, long term care, long term acute care, intermediate care, or when you do not need acute hospital inpatient care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting.* • *Custodial care; see Section 10.* Definitions . . . Custodial care • *Non-covered facilities, such as nursing homes, extended care facilities, and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
Services and supplies, such as: • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Physical, occupational, and speech therapy (when surgery performed on the same day) Note: When surgery is not performed on the same day, see Section 5(a). *Physical, occupational, and speech therapies* for coverage of these therapies.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center (cont.)	
Note: For accidental injuries, see Section 5(d). *Emergency services/accidents*. For accidental dental injuries, see Section 5(g). *Dental benefits*. Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental physical impairment or as the result of an accidental dental injury as defined in Section 5(g). *Dental benefits*. We do not cover the dental procedures or the anesthesia service when billed by the anesthesiologist. Note: Specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs dispensed in an outpatient hospital are subject to the Specialty Drug copayment. See *Outpatient hospital or ambulatory surgical center,* in this section.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
• Outpatient services and supplies for the delivery of a newborn • Outpatient services and supplies for a voluntary female sterilization	PPO: Nothing Non-PPO: 35% of the Plan allowance, and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Plan pays for pre-operative testing within 7 days of surgery. Screening tests, limited to: • Chest x-rays • Electrocardiograms • Urinalysis • Blood work Note: To reduce your out-of-pocket costs for laboratory services use LabCorp or Quest Diagnostics, see Section 5(a). *Lab, x-ray and other diagnostic tests.* Note: Diagnostic tests, such as magnetic resonance imaging, throat cultures, or similar studies are not considered as preadmission testing.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance, and the difference, if any, between our allowance and the billed amount
• Specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs Note: Prior approval is required for all specialty drugs used to treat chronic medical conditions. Call Caremark Specialty Pharmacy Services at 1-800-237-2767 to obtain prior approval, more information, or a complete list.	PPO: • 30-day supply: $150 • 60-day supply: $250 • 90-day supply: $350 Non-PPO: • 30-day supply: $150 and the difference, if any, between our Plan allowance and the charged amount • 60-day supply: $250 and the difference, if any, between our Plan allowance and the charged amount • 90-day supply: $350 and the difference, if any, between our Plan allowance and the charged amount

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center (cont.)	
Not covered: Personal comfort items	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
Limited to care in a skilled nursing facility (SNF) when your Medicare Part A is primary, and: • Medicare has made payment, we cover the applicable copayments; or • Medicare's benefits are exhausted, we cover semiprivate room, board, services, and supplies in a SNF, for the first 30 days of each admission or readmission to a facility, provided: 1. You are admitted directly from a hospital stay of at least 3 consecutive days; 2. You are admitted for the same condition as the hospital stay; and 3. Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.	PPO: Nothing Non-PPO: Nothing
Not covered: Custodial care	*All charges*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. Limited benefits: We pay a lifetime maximum Plan payment of $3000 for a combination of inpatient and outpatient services.	PPO: 15% of the Plan allowance, and all charges after we pay $3000 in a lifetime (calendar year deductible applies) Non-PPO: 30% of the Plan allowance, and all charges after we pay $3000 in a lifetime (calendar year deductible applies)
Not covered: • *Private nursing care* • *Homemaker services* • *Bereavement services*	*All charges*
Ambulance	
• Professional ambulance service to an outpatient hospital or ambulatory surgical center Note: When air ambulance transportation is provided by a non-PPO provider, we will pay up to the Plan allowance at the PPO benefit level.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
• Professional ambulance service to the nearest inpatient hospital equipped to handle your condition	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Ambulance - continued on next page

Benefit Description	You pay
Ambulance (cont.)	
Note: When air ambulance transportation is provided by a non-PPO provider, we will pay up to the Plan allowance at the PPO benefit level.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Transportation (other than professional ambulance services), such as by ambulette or medicab	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible 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 non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply, except as listed within this Section.
- Please keep in mind that when you use a PPO hospital or a PPO physician, some of the professionals that provide related services may **not** all be preferred providers. If they are not, they will be paid as non-PPO providers. However, we will process charges for radiology, pathology, the administration of anesthesia and the emergency room visit billed by non-PPO providers at the PPO benefit level, based on Plan allowance, if the services are rendered at a PPO hospital or PPO ambulatory surgical center.
- Be sure to read Section 4. *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

What is an accidental injury?

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

What is a medical emergency condition?

A medical emergency condition is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Medical emergency conditions, if not treated promptly, might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that are medical emergencies - what they all have in common is the need for quick action in order to avoid bodily injury, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

What are medical emergency services?

If you have a medical emergency condition, medical emergency services include a medical screening examination that is within the capability of the emergency department of a hospital, ancillary services routinely available to the emergency department to evaluate a medical emergency condition, further medical examination and treatment within the capabilities of the emergency facility, and stabilization of the emergency condition.

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: • Related nonsurgical treatment, including office or outpatient services and supplies • Related surgical treatment, limited to: - Simple repair of a laceration (stitching of a superficial wound) - Immobilization by casting, splinting, or strapping of a sprain, strain, or fracture • Local professional ambulance service to an outpatient hospital when medically necessary Note: For surgeries related to your accidental injury not listed above, see Section 5(b). *Surgical procedures*. Note: For inpatient hospital benefits related to an accidental injury, see Section 5(c). *Inpatient hospital*. Note: For dental benefits for accidental injury, see Section 5(g). *Dental benefits*.	PPO: Nothing (No deductible) Non-PPO: Nothing and the difference, if any, between the Plan allowance and the billed amount (No deductible)
Services received after 72 hours	Medical and outpatient hospital benefits apply. See Section 5(a). *Medical services and supplies provided by physicians and other health care professionals*, Section 5(b). *Surgical and anesthesia services provided by physicians and other health care professionals* and Section 5(c). *Outpatient hospital or ambulatory surgical center* for the benefits we provide.
Medical emergency	
Outpatient hospital medical emergency service for a medical emergency condition	PPO: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance and the difference, if any, between our allowance and the billed amount Note: When you need outpatient medical emergency services for a medical emergency and cannot access a PPO hospital, we will pay the non-PPO hospital charges, up to the Plan allowance, at the PPO benefit level.
Professional services of physicians and urgent care centers: • Office or outpatient visits • Office or outpatient consultations	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). *Surgical procedures*.	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

Benefit Description	You pay After the calendar year deductible…
Ambulance	
Local professional ambulance service when medically necessary, not related to an accidental injury Note: When air ambulance transportation is provided by a non-PPO provider, we will pay up to the Plan allowance at the PPO benefit level.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Transportation (other than professional ambulance services), such as by ambulette or medicab	*All charges*

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

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

When you receive care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for 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.
- The calendar year deductible 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 Out-of-Network benefits are the standard benefits of this Plan. In-Network benefits apply only when you use an In-Network provider. When no In-Network provider is available, Out-of-Network benefits apply.
- Be sure to read Section 4. *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PREAUTHORIZATION FOR THE FOLLOWING OUTPATIENT SERVICES:** Intensive outpatient program treatment, outpatient electro-convulsive treatment, psychological testing, methadone maintenance, and outpatient treatment visits beyond 45-50 minutes in duration with or without medication management. 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. See the instructions after the benefits descriptions below.
- **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.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
In-Network and Out-of-Network benefits	
• Outpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Outpatient medication management	In-Network: $20 copayment (No deductible) Out-of-Network: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Outpatient diagnostic tests • Inpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers	In-Network: 15% of the Plan allowance Out-of-Network: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

In-Network and Out-of-Network benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
In-Network and Out-of-Network benefits (cont.)	
• Lab and other diagnostic tests performed in an office or urgent care setting • Professional ambulance service to an outpatient hospital Note: When air ambulance transportation is provided by an Out-of-Network provider, we will pay up to the Plan allowance at the In-Network benefit level.	In-Network: 15% of the Plan allowance Out-of-Network: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
If LabCorp or Quest Diagnostics performs your covered lab services, you will have no out-of-pocket expense and you will not have to file a claim. Ask your doctor to use LabCorp or Quest Diagnostics for lab processing. To find a location near you, call 1-877-220-NALC (6252), or visit our Web site at www.nalc.org/depart/hbp.	Nothing (No deductible)
• Professional ambulance service to the nearest inpatient hospital equipped to handle your condition Note: When air ambulance transportation is provided by an Out-of-Network provider, we will pay up to the Plan allowance at the In-Network benefit level.	In-Network: 15% of the Plan allowance (No deductible) Out-of-Network: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (No deductible)
• Inpatient room and board provided by a hospital or other treatment facility • Other inpatient services and supplies provided by: - Hospital or other facility - Approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, and facility based intensive outpatient treatment	In-Network: $200 copayment per admission (No deductible) Out-of-Network: $350 copayment per admission and 30% of the Plan allowance (No deductible)
Not covered: • *Services we have not approved* • *Treatment for learning disabilities and mental retardation* • *Treatment for marital discord* • *Services by pastoral, marital, drug/alcohol, and other counselors except when preauthorized* • *Services rendered or billed by schools, residential treatment centers, or half-way houses, and members of their staffs except when preauthorized* • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a mental component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*

In-Network and Out-of-Network benefits - continued on next page

Benefit Description	You pay After the calendar year deductible…
In-Network and Out-of-Network benefits (cont.)	
• *Transportation (other than professional ambulance services), such as by ambulette or medicab* *Note: In medically underserved areas, we may cover services of pastoral counselors. See Section 3.* Covered providers. *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.* *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.*	*All charges*

Preauthorization

OptumHealth Behavioral Solutions provides our mental health and substance abuse benefits. Call 1-877-468-1016 to locate In-Network clinicians who can best meet your needs.

For services that require prior authorization, you must obtain a treatment plan and follow all of the following network authorization processes:

- Call 1-877-468-1016 to receive authorization to see a provider when we are your primary payor. You and your provider will receive written confirmation of the authorization from OptumHealth Behavioral Solutions for the initial and any ongoing authorizations.

Note: You do not need to preauthorize treatment for mental health and substance abuse services rendered outside of the United States.

- When Medicare is your primary payor, 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

Claims should be submitted to:

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

Note: If you are using an In-Network provider for mental health or substance abuse treatment, you will not have to submit a claim. OptumHealth Behavioral Solutions In-Network providers are responsible for filing.

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 75.
- 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 does not apply to prescription drug benefits.
- **SOME DRUGS REQUIRE PRIOR APPROVAL** before we provide benefits for them. Refer to the dispensing limitations in this section 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 how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

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

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

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

- **We use a formulary.** A formulary is a list of prescription drugs, both generic and brand name, that provide a safe, effective and affordable alternative to non-formulary drugs, which have a higher cost-share. Our formulary is open and voluntary. It is called the NALC Health Benefit Plan Drug List. If your physician believes a brand name drug is necessary, or if there is no generic available, ask your physician to prescribe a formulary brand name drug from our NALC Health Benefit Plan Formulary Drug List. You will pay the appropriate retail coinsurance and mail order copayment amounts for generic and formulary brand name drugs on this list. Your out-of-pocket costs will be higher for non-formulary brand name drugs not on the NALC Health Benefit Plan Formulary Drug List. To order this list, call 1-800-933-NALC (6252). When a generic medication is appropriate, ask your physician to prescribe a generic drug from our NALCSelect generic list. The amount you pay for a 90-day supply of an NALCSelect generic medication purchased through our mail order program, or at a CVS/Caremark Pharmacy through our Maintenance Choice Program is reduced. For a copy of our NALCSelect generic list, call 1-800-933-NALC (6252).

- **These are the dispensing limitations.**
  - For prescriptions purchased at NALC Preferred Network pharmacies and NALC CareSelect pharmacies you may obtain up to a 30-day fill plus one refill. If you purchase more than two fills of a maintenance medication at a network pharmacy without prior Plan authorization you will need to file a paper claim to receive a 55% reimbursement.
  - 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). The 21-day minimum does not apply to specialty drugs ordered through Caremark specialty pharmacy.
  - You may also purchase up to a 90-day supply (84-day minimum) of covered drugs and supplies at a CVS/Caremark Pharmacy through our Maintenance Choice Program. You will pay the applicable mail order copayment for each prescription purchased.

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 payor 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.

Specialty drugs are generally considered high-cost injectable, infused, oral or inhaled drugs that require close supervision and monitoring. You must purchase specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs, through the Caremark Specialty Pharmacy Services.

All specialty drugs require **prior approval** to ensure appropriate treatment therapies for chronic complex conditions (such as acute myelogenous leukemia (AML), age related macular degeneration, allergic asthma, cancer, Crohn's disease, cystic fibrosis, growth hormone disorder, hemophilia (and related bleeding disorders), hepatitis C, hereditary angioedema, HIV, immune deficiencies and related disorders, lysosomal storage disorders, multiple sclerosis, osteoarthritis, osteoporosis, psoriasis, pulmonary arterial hypertension, pulmonary disease, renal disease, respiratory syncytial virus, and rheumatoid arthritis). Examples of these drugs are Aralast, Avonex, Baygam, Cerezyme, Cinryze, Cytogam, Enbrel, Epogen, Factor VIII, Forteo, Fuzeon, Gleevec, Humatrope, Humira, Lucentis, Peg-Intron, Pulmozyme, Raptiva, Remicade, Recombinate, Respigam, Revatio, Sensipar, Supartz, Synagis, Xolair, and Zoladex. 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 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. Your out-of-pocket costs for mail order medications are reduced when your physician prescribes a generic medication from our NALCSelect generic list. Call 1-800-933-NALC (6252) to request a copy.
- **When you have Medicare Part D.** We waive the following at retail when Medicare Part D is primary payor and covers the drug:
  - Refill limitations
  - Day supply

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

- **When you have to file a claim.** If you purchase prescriptions at a non-network pharmacy, foreign/overseas pharmacy, or elect to purchase additional 30-day refills at a 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, medicine NDC number or name of drug, prescribing doctor's name, date of fill, total charge, metric quantity, days' supply, and pharmacy name and address or pharmacy NABP number.

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

NALC Prescription Drug Program
P.O. Box 52192
Phoenix, AZ 85072-2192

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

Benefit Description	You pay
Covered medications and supplies	
You may purchase the following medications and supplies from a pharmacy or by mail: • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by federal law of the United States require a physician's prescription for their purchase, except as shown in *Not covered* • Insulin • Needles and syringes for the administration of covered medications • Drugs for sexual dysfunction, when the dysfunction is caused by medically documented organic disease • Vitamins and minerals that by federal law of the United States require a physician's prescription for their purchase Note: You may purchase up to a 90-day supply (84-day minimum) of covered drugs and supplies at a CVS/Caremark Pharmacy through our Maintenance Choice Program. You will pay the applicable mail order copayment for each prescription purchased. Note: We will waive the one 30-day fill and one refill limitation at retail for patients confined to a nursing home, patients who are in the process of having their medication regulated, or when state law prohibits the medication from being dispensed in a quantity greater than 30 days. Call the Plan at 1-888-636-NALC (6252) to have additional refills at a network retail pharmacy authorized. Note: For coverage of the Herpes Zoster (shingles) vaccine, see Section 5(a). *Preventive care, adult.*	Retail: • Preferred network/Network retail: - Generic: 20% of cost - Formulary brand: 30% of cost - Non-formulary brand: 45% of cost • Non-network retail: 45% of the Plan allowance, and the difference, if any, between our allowance and the billed amount Retail Medicare: • Preferred network/Network retail Medicare: - NALCSenior Antibiotic generic: Nothing - Generic: 10% of cost - Formulary brand: 20% of cost - Non-formulary brand: 30% of cost • Non-network retail Medicare: 45% of the Plan allowance, and the difference, if any, between our allowance and the billed amount Mail order: • 60-day supply: $8 generic/$43 Formulary brand/$58 Non-formulary brand • 90-day supply: $5 NALCSelect generic • 90-day supply: $7.99 NALCPreferred generic • 90-day supply: $12 generic/$65 Formulary brand/$80 Non-formulary brand Mail order Medicare: • 60-day supply: $7 generic/$37 Formulary brand/$52 Non-formulary brand • 90-day supply: $4 NALCSelect generic • 90-day supply: $4 NALCPreferred generic • 90-day supply: $10 generic/$55 Formulary brand/$70 Non-formulary brand Note: If there is no generic equivalent available, you pay the brand name copayment. Note: If the cost of a prescription is less than the mail order copayment amount, you will pay the cost of the prescription. Note: Non-network retail includes additional fills of a maintenance medication at a Preferred Network/Network pharmacy without prior Plan authorization. This does not include prescriptions purchased at a CVS/Caremark Pharmacy through our Maintenance Choice Program.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
• FDA-approved prescription medications for tobacco cessation • Over-the-counter medications for tobacco cessation (prescription required) • FDA-approved prescription contraceptive drugs for women, including injectable drugs such as Depo provera • Diaphragms • Intrauterine devices	Retail: Preferred network/Network retail—nothing Retail Medicare: Preferred network/Network retail—nothing Mail order: • 60-day supply: nothing • 90-day supply: nothing Mail order Medicare: • 60-day supply: nothing • 90-day supply: nothing
• Prescription oral fluoride supplements for children from age 6 months through 5 years	Retail: Preferred network/Network retail—nothing Mail order: • 60-day supply: nothing • 90-day supply: nothing
Specialty drugs – including biotech, biological, biopharmaceutical, and oral chemotherapy drugs. All specialty drugs require prior approval. Examples of these drugs are Aralast, Avonex, Baygam, Cerezyme, Cinryze, Cytogam, Enbrel, Epogen, Factor VIII, Forteo, Fuzeon, Gleevec, Humatrope, Humira, Lucentis, Peg-Intron, Pulmozyme, Raptiva, Remicade, Recombinate, Respigam, Revatio, Sensipar, Supartz, Synagis, Xolair, Zoladex. Call Caremark Specialty Pharmacy Services at 1-800-237-2767 to obtain prior approval, more information, or a complete list.	Non-Medicare/Medicare: • Caremark Specialty Pharmacy Mail Order: - 30-day supply: $150 - 60-day supply: $250 - 90-day supply: $350 Note: Refer to dispensing limitations in this section.
Not covered: • *Drugs and supplies when prescribed for cosmetic purposes* • *Nutrients and food supplements, even when a physician prescribes or administers them* • *Over-the-counter medicines, vitamins, minerals, and supplies, except as listed above* • *Over-the-counter tobacco cessation medications purchased without a prescription* • *Tobacco cessation medications purchased at a non-network retail pharmacy* • *Prescription oral fluoride supplements purchased at a non-network retail pharmacy* • *Prescription contraceptives for women purchased at a non-network retail pharmacy* • *Over-the-counter contraceptives purchased without a prescription* • *Prescription drugs for infertility*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
Note: See Section 5(h). Special Features *for information on the CaremarkDirect Program where you may obtain non-covered medications at a discounted rate.*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and (d), the calendar year deductible applies to only a few benefits. In that case, we say "(calendar year deductible applies)." The calendar year deductible is $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, except as listed within this Section.
- Please keep in mind that when you use a PPO hospital or a PPO physician, some of the professionals that provide related services, may **not** all be preferred providers. If they are not, they will be paid as non-PPO providers. However, we will process charges for radiology, pathology, the administration of anesthesia and the emergency room visit billed by non-PPO providers at the PPO benefit level, based on Plan allowance, if the services are rendered at a PPO hospital or PPO ambulatory surgical center.
- Be sure to read Section 4. *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

What is an accidental dental injury?

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

What is a sound natural tooth?

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

Benefit Description	You pay
Note: The calendar year deductible applies ONLY when we say, "(calendar year deductible applies)."	
Accidental dental injury benefit	
We only cover outpatient dental treatment incurred and completed within 72 hours of an accidental injury (as defined above). We provide benefits for services, supplies, or appliances (such as space maintainers) for dental care necessary to repair injury to sound natural teeth (as defined above) required as a result of, and directly 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 (calendar year deductible applies)
Not covered: • *Dental services not rendered or completed within 72 hours* • *Bridges, oral implants, dentures, crowns* • *Orthodontic treatment*	*All charges*

Section 5(h). Special features

Special feature	Description
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.
24-hour nurse line	Call CareAllies 24-Hour Nurse Line at 1-877-220-NALC (6252) to access a registered nurse 24 hours a day, 7 days a week. This nurse line seeks to influence consumer behavior by providing tools, education, counseling and support to help members make decisions with respect to their health and use of healthcare services. Consumers may contact a CareAllies registered nurse at any time of the day or night, for: • Answers to questions about medical conditions, diagnostic tests or treatments prescribed by their physicians, or other health or wellness topics • Assistance to determine the appropriate level of healthcare services (emergency room, doctor visit, self care, etc.) required to address a current symptom • Self care techniques for home care of minor symptoms • Referrals for case management or other appropriate services • Introduction to the online health resources available at www.nalc.org/depart/hbp
CaremarkDirect Program	You can purchase non-covered drugs through the Caremark mail service pharmacy and receive the convenience, safety, and confidentiality you already benefit from with covered prescriptions. CaremarkDirect is offered at no additional charge to you. Using the mail service program for both covered and non-covered prescriptions will help ensure overall patient safety. CaremarkDirect is a value-added program that provides you with safe, convenient access to competitively priced, non-covered prescriptions, and certain over-the-counter drugs. You may call 1-800-933-NALC (6252), 24 hours a day, 7 days a week, for a complete listing of available medications and their cost.
Childhood Weight Management Resource Center	Visit our Web site at www.nalc.org/depart/hbp for information and tips on weight management and overcoming childhood obesity. You can access numerous articles on food, nutrition, exercise and fitness specifically geared for children of all ages. You can also find recipes, meal suggestions, and a BMI chart designed for children from age 2 through 20. Through this on-line tool, parents can sign up for a free OptumHealth Live and Work Well monthly email newsletter that can be tailored to their child's age and special interests.
Disease management programs - Alere™ Health Management	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 chronic heart failure, coronary artery disease, chronic obstructive pulmonary disease, diabetes, and asthma. Call Alere™ Health Management at 1-866-270-2202 for more information.
Disease management program – Gaps in Care	This program integrates medical, pharmacy, and laboratory data to identify and address members' gaps in care. Gaps in care occur when individuals do not receive or adhere to care that is consistent with medically proven guidelines for prevention or treatment. This is an outreach program for both you and your physician. Members and their physicians are informed by mail of potential gaps and are instructed on how to improve adherence to existing therapies. Some examples of conditions that are managed through the program are: diabetes, hypertension, and cardiac disorders.

Special feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. 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 in addition to other terms as necessary. 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 do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract 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. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Health Risk Assessment (HRA)	A free Health Risk Assessment (HRA) is available under the 'Personal Health Record' tab at www.nalc.org/depart/hbp. The HRA is an online program that analyzes your health related responses and gives you a personalized plan to achieve specific health goals. Your HRA profile provides information to put you on a path to good physical and mental health. Once you complete the HRA, we will waive one $20 copayment (when the Plan is the primary payor) for the next in-network medical office visit or consultation incurred in the same calendar year that the HRA is completed. The Plan will waive two $20 office visit copayments annually (when the Plan is the primary payor) for a Self and Family policy when at least two family members complete an HRA.
Healthy Rewards Program	A program available to all members that provides discounts on services that are not usually covered by the Plan. You will receive discounts on weight management and nutrition services, fitness clubs, vision and hearing care, magazine subscriptions, and healthy lifestyle products. This program promotes wellness, good health, and healthy behaviors. For more information call 1-800-558-9443 or visit our Web site at www.nalc.org/depart/hbp.
Personal Health Record	Our Personal Health Record allows you to create and maintain a complete, comprehensive, and confidential medical record containing information on allergies, immunizations, medical providers, medications, past medical procedures, and more. Participation is voluntary and access is secured. To access, register at www.nalc.org/depart/hbp, log on and select the 'Personal Health Record' tab.
Services for deaf and hearing impaired	TTY lines are available for the following: CAREMARK: 1-800-238-1217 (prescription benefit information) OptumHealth Behavioral Solutions: 1-800-842-2479 (mental health and substance abuse information)

Special feature	Description
Solutions for Caregivers (formerly called Enhanced Eldercare Services)	For members or spouses that are caring for an elderly relative or disabled dependent, this program provides expert assistance from a Care Advocate, a registered nurse with geriatric, disability and community health experience. Your benefit gives you a bank of six free hours per calendar year, which may be used for any combination of the following services: • Evaluating the elder's/dependent's living situation • Identifying medical, social and home needs (present and future) • Recommending a personalized service plan for support, safety and care • Finding and arranging all necessary services • Monitoring care and adjusting the service plan when necessary Whether it's arranging transportation to doctors' appointments, explaining insurance options, having safety equipment installed, or coordinating care with multiple providers, the Care Advocate will help ensure that your elderly relative or disabled dependent maintains a safe, healthy lifestyle. You also have the option to purchase continuing services beyond the six hours offered. You must call 1-877-468-1016, 24 hours a day, 7 days a week, to access the services of Solutions for Caregivers. 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.
Weight Management Program	The Cigna Healthy Steps to Weight Loss - Weight Management Program guides each person in creating their own tailored healthy living plan to help them eat right, participate in regular physical activity, and adopt habits that will lead to a healthy weight for life. The program is a non-diet approach to weight loss with an emphasis on changing habits. Each person seeking assistance with behavior change responds to treatment options in his or her own unique way. The program format is tailored to each individual's learning style and level of readiness to make a behavior change. Participants, with the guidance of a Wellness Coach, a trained health professional, may select the online mode or the telephone coaching model. The Wellness Coach assesses participants for their BMI, health status, motivation, self-efficacy, food choices, sleep patterns, stress level, and other relevant risk factors and co-morbidities as well as readiness to change. A toolkit is sent to each coaching program participant to assist him or her in achieving their plan goals. Individuals may register online at www.nalc.org/depart/hbp or by calling the toll-free number at 1-877-220-NALC (6252). A Wellness Coach is available Monday-Friday 8:00 a.m. to 8:00 p.m. and Saturday 8:00 a.m. to 5:00 p.m.
Worldwide coverage	We cover the medical care you receive outside the United States, subject to the terms and conditions of this brochure. See Section 7. *Overseas claims.*

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

The benefits described on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB plan deductibles or out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-888-636-NALC (6252).

Cigna*Plus* Savings SM (discount dental program)

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

Hospital Plus (hospital indemnity)

Hospital Plus is a hospital indemnity policy available for purchase from the United States Letter Carriers Mutual Benefit Association. This policy may be purchased throughout the year and is not subject to the health benefit plan open season. **This is available only to letter carriers who are members in good standing with the National Association of Letter Carriers, their spouses, children, and retired NALC members.**

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

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

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

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

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

Important Notice Regarding Membership Dues

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

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

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

Call Membership at 202-662-2856 for inquires regarding membership, union dues, fees, or information on the NALC union.

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

Section 6. General exclusions – services, drugs, and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3. *When you need prior Plan approval for certain services*.

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.
- Services, drugs, or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services, drugs, or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage, or adoption.
- Services, drugs, or supplies furnished or billed by a non-covered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Charges which the enrollee or Plan have no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 97), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 97), or State premium taxes, however applied.
- 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.
- Therapy (other than speech, physical, and occupational therapy) including Applied Behavioral Analysis (ABA) for autism.
- Transportation (other than professional ambulance services or travel under the Cigna ***Life***SOURCE Transplant Network®).
- Dental services and supplies (except those oral surgical procedures listed in Section 5(b*). Oral and maxillofacial surgery* and Section 5(g). *Dental benefits).*
- Services for and/or related to procedures not listed as covered.
- Charges in excess of the Plan allowance.
- Treatment for cosmetic purposes and/or related expenses.
- Custodial care (see Section 10. *Definitions of terms we use in this brochure*).

- Fraudulent claims.
- Services, drugs, or supplies related to "Never Events". "Never Events" are errors in care that can and should be prevented. The Plan will deny payments where the patient cannot legally be held liable.
- Genetic counseling and/or genetic screening (except as specifically listed in Section 5(a). *Preventive care, adult*; *Preventive care, children* ; and *Maternity care*).

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

How to claim benefits

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

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. When Medicare is not the primary payor, claims should be submitted directly to Cigna at the address shown on the reverse side of your identification card.

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

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

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Member identification number 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
- Type of each service or supply
- 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:

- If another health plan is your primary payor, you must send a copy of the explanation of benefits (EOB) form you received from your primary payor (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.).
- If your claim is for the rental or purchase of durable medical equipment, home health services, physical therapy, occupational therapy, or speech therapy, you must provide 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 patient's name, prescription number, medicine NDC number or name of drug or supply, prescribing physician's name, date of fill, total charge, metric quantity, days' supply, and pharmacy name and address or pharmacy NABP number.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Records

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

Deadline for filing your claim

Send us all 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. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States, send the itemized bills to:

NALC Health Benefit Plan
20547 Waverly Court
Ashburn, VA 20149

Claims for prescription drugs and supplies purchased outside the United States and Puerto Rico must include receipts that show the patient's name, prescription number, name of drug or supply, prescribing physician's name, date of fill, total charge, metric quantity, days' supply and name of pharmacy. Complete the short-term prescription claim form, attach the drug receipts and mail to the NALC Prescription Drug Program.

NALC Prescription Drug Program
P.O. Box 52192
Phoenix, AZ 85072-2192

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. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

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.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

The Secretary of Health and Human Services has identified counties where at least 10 percent of the population is literate only in certain non-English languages. The non-English languages meeting this threshold in certain counties are Spanish, Chinese, Navajo and Tagalog. If you live in one of these counties, we will provide language assistance in the applicable non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.nalc.org/depart/hbp.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3. *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149 or calling 703-729-4677 or 1-888-636-NALC (6252).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a Plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: NALC Health Benefit Plan, 20547 Waverly Court, Ashburn, VA 20149; and 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 (EOB) forms. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim; or b) Write to you and maintain our denial; or c) Ask you or your provider for more information.

	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 2, 1900 E Street, NW, Washington, DC 20415-3620. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 703-729-4677 or 1-888-636-NALC (6252). We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at 202-606-3818 between 8:00 a.m. and 5:00 p.m., Eastern time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this Plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Worker's Compensation Programs if you are receiving Worker's Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. Like other insurers, we determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC Web site at http://www.NAIC.org.

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

When we are the secondary payor, 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.

- **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 (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws. If OWCP or a similar agency disallows benefits or pays its maximum benefit for your treatment, we will pay the benefits described in this brochure.

- **Medicaid**

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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

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

Clinical trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, and is either Federally-funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health Plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. This Plan only covers:
  - Items or services that are typically provided absent a clinical trial such as conventional care;

- Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service such as additional charges incurred for the diagnosis or treatment of complications resulting from patient participation in a clinical trial.

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials and this Plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

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

Medicare has 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), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage plans on page 95.
- 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, (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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

Note: Please refer to page 97 for information about how we provide benefits when you are age 65 or older and do not have Medicare.

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

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

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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 payor, we process the claim first.
- When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file a claim, call us at 703-729-4677 or 1-888-636-NALC (6252).

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

- If you have Medicare Part A as primary payor, 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 payor, we waive:

- The copayments for office or outpatient visits.
- The copayments for allergy injections.
- The coinsurance for services billed by physicians, other health care professionals, and facilities.
- All calendar year deductibles.

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

You can find more information about how our plan coordinates benefits with Medicare in Medicare and You, and Medicare Benefits at a Glance at www.nalc.org/depart/hbp.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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), (TTY 1-877-486-2048) 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 payor, we will pay the lesser of the balance after Medicare pays or our drug benefit.

See 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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

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

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

Under the FEHB law, we must limit our payments for **inpatient hospital care** and **physician care** to those payments you would be entitled to if you had Medicare. Your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. You and the FEHB benefit from these payment limits. Outpatient hospital care and non-physician based care are not covered by this law; regular Plan benefits apply. The following chart has more information about the limits.

If you:

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

Then, for your inpatient hospital care:

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

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

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

If your physician:	Then you are responsible for:
Participates with Medicare or accepts Medicare 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. A Medicare non-participating provider is a provider who has not enrolled in Medicare and does not accept Medicare payments. You are responsible for applicable deductibles, coinsurance, or copayments for charges billed by Medicare non-participating providers. A Medicare opt-out provider is a provider who has elected to leave the Medicare program and is not eligible to receive Medicare benefits. We require a signed copy of the provider opt-out contract with Medicare. Charges are processed by estimating the amount Medicare would have paid if billed by a Medicare participating provider.

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.

Note: When Medicare benefits are exhausted, or services are not covered by Medicare, our benefits are subject to the definitions, limitations, and exclusions in this brochure. In these instances, our payment will be based on our non-PPO Plan allowance.

Section 10. Definitions of terms we use in this brochure

Admission

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

Assignment

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

Calendar year

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

Coinsurance

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

Clinical Trials Cost Categories

The clinical trials cost categories are:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Congenital anomaly

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

Copayment

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

Cosmetic surgery

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

Cost-sharing

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

Covered services

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

Custodial care

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

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

The Plan determines whether services are custodial care.

Deductible

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

Effective date

The effective date of benefits described in this brochure is:

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

Experimental or investigational service

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

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

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

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

Group health coverage

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

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law. See Section 3. *How you get care* for a listing of covered providers.

Medical necessity

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

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

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

Mental health and substance abuse

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

Plan allowance

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

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

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

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

- Our Plan allowance is based on the 80th percentile of data gathered from health care sources that compare charges of other providers for similar services in the same geographic area; or
- For facility charges (such as hospitals, dialysis facilities, and ambulatory surgical centers), our allowance is based on two and one-half times the Medicare reimbursement rate.
- For medication charges, our allowance is based on the suggested wholesale price or an alternative pricing benchmark.

  Note: If you purchase prescriptions at a non-network pharmacy, foreign/overseas pharmacy, or elect to purchase additional 30-day refills at a network pharmacy, CVS Caremark will base its allowance on the average wholesale price. For medication charges, our allowance is based on the average wholesale price or an alternative pricing benchmark.

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.

Non-PPO medical emergency services:
Our Plan allowance for non-PPO emergency services is determined by taking the greatest of:

- The median PPO rate;
- The usual, customary and reasonable rate (or similar rate determined using the Plan's formula for determining payments for non-PPO services); or
- The Medicare rate.

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.*

Post-service claims	Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.
Preadmission testing	Routine tests ordered by a physician and usually required prior to surgery or hospital inpatient admission that are not diagnostic in nature.
Pre-service claims	Those claims (1) that require precertification, preauthorization, or prior approval and (2) where failure to obtain precertification, preauthorization, or prior approval results in a reduction of benefits.
Urgent care claims	A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts: • Waiting could seriously jeopardize your life or health; • Waiting could seriously jeopardize your ability to regain maximum function; or • In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 703-729-4677 or 1-888-636-NALC (6252). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.
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. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB Program

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

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider file claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **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 tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

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

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

Important information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.
Vision insurance	All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection	The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program - *PCIP*

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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

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Summary of benefits for the NALC Health Benefit Plan - 2013

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 $300 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a non-PPO physician or other health care professional.

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $20 copayment per office visit; $5 copayment per allergy injection; routine screening services and other nonsurgical services, 15% of our allowance Non-PPO: 30% of our allowance	32
Services provided by a hospital:		
• Inpatient	PPO: Nothing when services are related to the delivery of a newborn. $200 copayment per admission for all other admissions. Non-PPO: $350 copayment per admission and 30% of our allowance	60
• Outpatient	PPO: 15% of our allowance Non-PPO: 35% of our allowance	62
Emergency benefits:		
• Accidental injury	Within 72 hours: Nothing for nonsurgical outpatient care, simple repair of laceration and immobilization of sprain, strain, or fracture After 72 hours: PPO: Regular cost-sharing Non-PPO: Regular cost-sharing	67 67
• Medical emergency	PPO: 15% of our allowance Non-PPO: 15% of our allowance	67
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Prescription drugs:		
• Retail pharmacy		75

	Preferred Network/Network: Generic: 20% of cost; Formulary brand: 30% of cost;Non-formulary brand: 45% of cost Preferred Network/Network Medicare: NALCSenior Antibiotic generic: Nothing Generic: 10% of cost; Formulary brand: 20% of cost; Non-formulary brand: 30% of cost Non-network: 45% of our allowance Non-network Medicare: 45% of our allowance	
• Mail order	Non-Medicare: 60-day supply, $8 generic/$43 Formulary brand/$58 Non-formulary brand Non-Medicare: 90-day supply, $5 NALCSelect generic Non-Medicare: 90-day supply, $7.99 NALCPreferred generic Non-Medicare: 90-day supply, $12 generic/$65 Formulary brand/$80 Non-formulary brand Medicare: 60-day supply, $7 generic/$37 Formulary brand/$52 Non-formulary brand Medicare: 90-day supply, $4 NALCSelect generic Medicare: 90-day supply, $4 NALCPreferred generic Medicare: 90-day supply, $10 generic/$55 Formulary brand/$70 Non-formulary brand Non-Medicare/Medicare: 30-day supply, $150 specialty drug Non-Medicare/Medicare: 60-day supply, $250 specialty drug Non-Medicare/Medicare: 90-day supply, $350 specialty drug	75
Prescription medications for tobacco cessation:		
• Retail pharmacy	Preferred network/Network retail, Nothing Medicare Preferred network/Network retail, Nothing	76
• Mail Order	Non-Medicare: 60-day supply, Nothing Non-Medicare: 90-day supply, Nothing Medicare: 60-day supply, Nothing Medicare: 90-day supply, Nothing	76
Dental care:	All charges except as listed in Section 5(g). under the *Accidental dental injury benefit.*	78
Special features:	• 24-hour help line for mental health and substance abuse • 24-hour nurse line • CaremarkDirect Program • Childhood Weight Management Resource Center • Disease management programs - Alere™ Health Management • Disease management programs - Gaps in Care • Flexible benefits option	79

	• Health Risk Assessment (HRA) • Healthy Rewards Program • Personal Health Record • Services for deaf and hearing impaired • Solutions for Caregivers (formerly called Enhanced Eldercare Services) • Weight Management Program • Worldwide coverage	
Protection against catastrophic costs (out-of-pocket maximum)**:**	Services with coinsurance (including mental health and substance abuse care), nothing after your coinsurance expenses total: • $5000 for PPO providers/facilities • $7000 for Non-PPO providers/facilities. When you use a combination of PPO and Non-PPO providers your out-of-pocket expense will not exceed $7000. • $4000 per person or family for coinsurance for prescription drugs dispensed by an NALC Preferred/NALC CareSelect network pharmacy and copayment amounts for specialty drugs dispensed by Caremark Specialty Pharmacy. Some costs do not count toward this protection.	28

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2013 Rate Information for the NALC Health Benefit Plan

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

Postal Category 1 rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2 rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:
Human Resources Shared Service Center
1-877-477-3273, option 5
TTY: 1-866-260-7507

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

Note: All USPS Postal Employees are required to pay full local branch dues. Associate dues are not available.

Note: Non-postal employees, federal annuitants, non-NALC Union annuitants, and other Postal annuitants must pay the annual $36.00 Associate Membership Fee in order to maintain membership in the NALC Health Benefit Plan. For further explanation, please see the front cover and page 82 of this brochure.

Note: Call Membership at 202-662-2856 for inquires regarding membership, union dues, fees, or information on the NALC union.

Note: The Self Only premium for a USPS Transitional Employee (TE) is $264.99. The Self and Family premium for a USPS Transitional Employee (TE) is $575.43. In accordance with 5 U.S.C. Section 8906a, Transitional Employees (TE) are required to pay the entire premium including both the employee share and the Government contribution. Please visit our Web site at www.nalc.org/depart/hbp for more information.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	321	$190.84	$74.15	$413.49	$160.66	$52.95	$58.25
High Option Self and Family	322	$424.95	$150.48	$920.73	$326.04	$103.26	$115.07