NALC Health Benefit Plan for Employees and Staff

2012

A Plan for employees of the National Association of Letter Carriers, the NALC Health Benefit Plan and the United States Letter Carriers Mutual Benefit Association.

Type of Enrollment	Enrollment Code
Self Only ……	321
Self and Family ……	322

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Introduction

NALC Health Benefit Plan for Employees and Staff
P.O. Box 678
Ashburn, VA 20146
703-729-4677 or 1-888-636-NALC (6252)

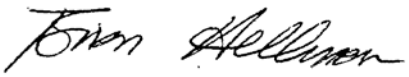
We are pleased to present this brochure describing the program of health benefits for covered employees, retirees, and their families under the NALC Health Benefit Plan for Employees and Staff.

This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

This brochure describes the benefits, exclusions, limitations, and maximums effective January 1, 2012 for calendar year 2012 only. A participant in the Staff Plan does not have a vested right to receive the benefits in this brochure in 2013 or in later years and does not have a right to benefits available prior to 2012 unless those benefits are also contained in this brochure. Oral statements cannot modify the benefits described in this brochure.

We urge you to become familiar with the benefit program and to keep this brochure available for reference.

Fredric V. Rolando
President, NALC
Administrator, NALC Health Benefit Plan for Employees and Staff



Brian E. Hellman
Assistant Administrator,
NALC Health Benefit Plan for Employees and Staff

Board of Trustees

Randall L. Keller Lawrence D. Brown, Jr., Ch. Michael J. Gill

Summary Plan Description

This brochure is the Summary Plan Description and the official Plan document of the NALC Health Benefit Plan for Employees and Staff.

Plain Language

This brochure is written in plain language to make it more responsive, accessible, and understandable to the public. For instance;

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means NALC Health Benefit Plan for Employees and Staff.
- When we use acronyms, we will tell you what they mean first.

Identification Information

Name of the Plan	NALC Health Benefit Plan for Employees and Staff
Names and address of Employers*	National Association of Letter Carriers 100 Indiana Avenue, NW Washington, DC 20001 NALC Health Benefit Plan 20547 Waverly Court Ashburn, VA 20149 United States Letter Carriers Mutual Benefit Association 100 Indiana Avenue, NW Washington, DC 20001

*A complete list of contributing employers may be obtained by covered persons upon written request to the Plan Administrator and is available for examination at the Plan's office.

Employer ID number	54-1875242
Plan number	501
Type of plan	Employee Welfare Benefit Plan providing for hospitalization, surgical, major medical, prescription drug, and related benefits
Type of administration	All benefits are self-insured and self-administered, except for mental health and substance abuse benefits, which are administered and insured by OptumHealth℠ Behavioral Solutions.
Plan Administrator	Fredric V. Rolando, President National Association of Letter Carriers 100 Indiana Avenue, NW Washington, DC 20001
Trustees	Lawrence D. Brown, Jr., Ch. c/o NALC Health Benefit Plan for Employees and Staff PO Box 678 Ashburn, VA 20146 Randall L. Keller c/o NALC Health Benefit Plan for Employees and Staff PO Box 678 Ashburn, VA 20146 Michael J. Gill c/o NALC Health Benefit Plan for Employees and Staff PO Box 678 Ashburn, VA 20146
Agent for service of legal process	Brian E. Hellman, Assistant Administrator NALC Health Benefit Plan for Employees and Staff PO Box 678 Ashburn, VA 20146 Service of legal process may also be made upon the Plan Administrator or any Trustee

Collective bargaining agreements	The Plan is maintained pursuant to collective bargaining agreements between the NALC, the NALC HBP, and the USLC MBA and the Office of Professional Employees International Union, AFL-CIO, the International Union of Operating Engineers and the Service Employees' International Union in that some participants in the Plan are employees who are covered by collective bargaining agreements. Copies of the agreements may be obtained upon written request to the Plan Administrator and are available for examination at the Employers' offices.
Fiscal year	For purposes of maintaining the Plan's fiscal record, the year end date is December 31.
Sources of contributions and funding	The Plan is funded through contributions made by the Employers and by participants. The assets of the Plan are held in trust.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone.

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 or plan.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Do not ask your physician to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 703-729-4677 or 1-888-636-NALC (6252) and explain the situation.
- 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 older (unless he/she became disabled and incapable of self support prior to age 26 and the Staff Plan has approved enrollment).
  - If you have any questions about the eligibility of a dependent, check with the Nongroup Department.

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

Preventing medical mistakes

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

1. **Ask questions if you have doubts or concerns.**
   - Ask questions and make sure you understand the answers.
   - Choose a doctor with whom you feel comfortable talking.
   - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
   - Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
   - Tell them about any drug allergies you have.

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

3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures.
   - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
   - Call your doctor and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:

     "Exactly what will you be doing?"

     "About how long will it take?"

     "What will happen after surgery?"

     "How can I expect to feel during recovery?"
   - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

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, if you use a CIGNA HealthCare Shared Administration OAP Network Preferred Provider or if Medicare as well as any state or other laws apply, neither the Plan nor you will incur costs to correct the medical error.

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

This Plan is a fee-for-service (FFS) plan. You can choose your own physicians, hospitals, and other health care providers. We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow.

All Employees as defined on page 106 are automatically eligible for coverage under the Plan effective on the first day in pay and duty status. Employees with eligible dependents are eligible for Self and Family coverage.

All coverage is subject to timely payment of required premiums. See Section 10. *Eligibility* for additional information. For information about premiums, please contact the Nongroup Department at 703-729-4677 or 1-888-636-NALC (6252).

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 site www.nalc.org/depart/hbp.

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 or by a PPO physician, we will pay up to the Plan allowance for radiology, pathology, the administration of anesthesia and the emergency room visit charges if billed by non-PPO providers. 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 providers (PPO or non-PPO), we share the savings with you.

Reservation of rights

It is anticipated that the Plan will remain in effect indefinitely. However, the Administrator and the Board of Trustees reserve the right to amend, modify, or terminate the Plan at any time, in accordance with the Agreement and Declaration of Trust governing the Plan. The Administrator and the Trustees specifically reserve the right to change, eliminate, or add to the benefits provided to participants and beneficiaries and the rules concerning eligibility for such benefits. They also reserve the right to adopt new rules and regulations, to modify the rules and regulations, and to terminate the existing Plan. No benefits or rules of the Plan are guaranteed (vested) for any participant or eligible dependent. All benefits and rules may be changed, reduced, or eliminated at any time by the Administrator and the Board of Trustees, in their sole discretion. Material modifications to the plan of benefits or the rules adopted by the Administrator and the Board of Trustees will be communicated in writing and distributed to participants, as required by law, so that the participants may have current information concerning their rights and benefits. If the Plan is terminated, any Plan assets will be used to pay for eligible expenses incurred prior to the Plan's termination and will be paid as provided under the terms of the Plan prior to its termination.

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. See our Notice of Privacy Practices on pages 11-14 for additional information.

You have a right to the following information

The Patients' Bill of Rights gives you the right to information about your health plan, its networks, providers, and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs, and how we determine if procedures are experimental or investigational.

If you want specific information about us, call 703-729-4677 or 1-888-636-NALC (6252), or write to NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146.

The Plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). Call the Nongroup Department at 703-729-4677 or 1-888-636-NALC (6252) for more information.

Our Plan meets the requirements under the Women's Health and Cancer Rights Act of 1998 (WHCRA) by providing benefits to individuals who have had or is going to have a mastectomy for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prosthesis; and
- Treatment of physical complication of the mastectomy, including lymphedema.

Coverage will be provided in a manner determined in consultation with the attending physician and the patient, as may be necessary, and will be subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan.

Please contact the Nongroup Department at 703-729-4677 or 1-888-636-NALC (6252) with any questions concerning mastectomy-related benefits.

What type of benefits are provided?

Each year, Staff Plan benefits conform to the medical/surgical/hospital benefits provided to Federal employees who enroll in the NALC Health Benefit Plan under U.S. Office of Personnel Management Contract CS 1067. The benefits described in this brochure are in effect for the year 2012. Changes in benefits to be effective in future years are communicated during the Plan's annual Open Season.

Notice of the NALC Health Benefit Plan for Employees and Staff'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.

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.

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.

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.

- Regarding Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

- Disclosures to Plan Administrator and Trustees: We may disclose PHI to the Plan Administrator, Assistant Administrator, or Trustees of the Plan in connection with appeals that you file following the denial or partial payment of a benefit claim. In addition, the Plan Administrator or any Trustee can receive PHI if you request the Administrator or Trustee to assist you in your filing or perfecting a claim for benefits from the Plan. The Plan Administrator and Trustees may also receive PHI as necessary for them to fulfill their duties with respect to the Plan. Such disclosures will be the minimum necessary to achieve the purpose of the use or disclosure. The Administrator and Trustees agree not to use or disclose PHI other than as permitted or required by law, and not to use or disclose the PHI with respect to employment-related decisions or actions or with respect to any other benefit plan they maintain.

- Disclosures Required by Law: We may use or disclose your PHI to the extent we are required to do so by federal, state, or local law. You will be notified, if required by law, of any such uses or disclosures.

- Persons Involved in Your Health Care: Unless, we agree to your request that we not do so, HIPAA permits us to disclose to your immediate family member, close personal friend or any other person whom you identify to us PHI that is directly relevant to that person's involvement in your health care or payment of your health care.

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 in accordance with the HIPAA privacy law and regulations.

We must have your authorization to use or disclose your PHI 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.

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 VII. *How to Contact Us*. 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.

Your Health Information Rights

Although documents provided to or otherwise held by the NALC Health Benefit Plan for Employees and Staff are our property, the protected health information contained in those documents belongs to you. With respect to protected health information, you have these rights:

- The right to see and get a copy of your PHI. 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 PHI 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.

Our Responsibilities to You

We at the National Association of Letter Carriers Health Benefit Plan for Employees and Staff 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.

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.

How to Contact Us

If you have questions, you may call our Nongroup 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 for Employees and Staff
P.O. Box 678
Ashburn, VA 20146

Effective Date

The terms of this Notice are in effect as of January 1, 2012.

Section 2. How we change for 2012

This is a summary of benefit changes effective January 1, 2012. For the official statement of these and other benefits please refer 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.

Changes to this Plan

- South Carolina has been removed from the list of Medically Underserved Areas and Alaska has been added for 2012. (see page 17)
- We now cover state licensed and state certified acupuncturists. Previously, we only covered acupuncture when performed by a doctor of medicine or osteopathy. (see page 42)
- We now require prior authorization for outpatient radiology/imaging services to include CT/CAT, MRI, MRA, NC, and PET scans. (see page 20)
- We added coverage for vaccination with Tetanus-diphtheria, pertussis (Tdap), for adults age 65 and older. (see page 30)
- We now cover Haemophilus influenza type b (Hib) vaccine for adults age 19 and older with medical indications as recommended by the Centers for Disease Control (CDC). (see page 29)
- We now cover osteoporosis screening as recommended by the U.S. Preventive Services Task Force (USPSTF). Previously, we covered osteoporosis screening for women age 60 and older. (see page 31)
- You now pay 30% (after the calendar year deductible) for preventive care for children when rendered by a non-PPO provider. Previously, you paid nothing. (see page 32)
- We now cover the meningococcal vaccine for children as recommended by the American Academy of Pediatrics (AAP). Previously, this benefit had a lifetime limitation of two vaccinations. (see page 32)
- We now cover one vision screening for amblyopia or its risk factors for children between the ages of 3 and 5 years, as recommended by the U.S. Preventive Services Task Force (USPSTF). Previously, we covered one screening examination for amblyopia and strabismus for children age 2 through 6. (see page 32)
- You now pay nothing for Group B streptococcus infection screening, sonograms, and fetal monitoring as part of your maternity care when rendered by a PPO provider. Previously, you paid 15%. (see page 33)
- We now limit our payment of charges for covered infertility treatment to $2500 per calendar year and drugs prescribed for the treatment of infertility are not covered. Previously, there was no maximum benefit and prescription drugs used to treat infertility were covered. (see page 35)
- You now pay $20 per visit for physical, occupational, and speech therapies when rendered by a PPO provider. Previously, you paid $15 per visit. (see page 37)
- We now cover 20 Chiropractic spinal manipulations per calendar year. Previously, we covered 12 manipulations per calendar year. (see page 41)
- We now limit the number of acupuncture visits to 15 per person per calendar year. (see page 42)
- We added coverage for autologous blood or marrow stem cell transplants limited to an approved clinical trial when approved by the Plan for the following conditions: Childhood rhabdomyosarcoma, Advanced Ewing sarcoma, Advanced childhood kidney cancers, and Mantle Cell (non-Hodgkin's lymphoma). (see page 49)
- You now pay nothing for delivery of a newborn in an outpatient PPO facility. Previously, you paid 15%. (see page 56)
- We now waive one $20 office visit copayment (two for Self and Family) when you complete the Health Risk Assessment (HRA). (see page 71)

Clarifications

- We clarified who is eligible to receive a routine meningococcal vaccine under the *Preventive care, adult* benefit. (see page 32)
- We clarified that intrauterine contraceptive devices purchased at a retail pharmacy or through the NALC mail order prescription drug program are covered under the Prescription drug benefit. (see page 34)
- We clarified that you pay a separate copayment for each type of therapy when physical, occupational and/or speech therapy are performed on the same day and rendered by a PPO provider. (see page 36)
- We clarified that physical therapy rendered by a chiropractor is covered when the service performed is within the scope of his/her state license. (see page 41)
- We clarified the Plan will cover the office visit that is rendered on the same day as a covered chiropractic spinal manipulation. (see page 42)
- We updated the criteria for coverage of bariatric surgeries. (see page 44)
- We clarified your costs for services rendered by a CIGNA LIFESOURCE Transplant Network® provider. (see page 51)
- We clarified that we will pay anesthesia rendered by a non-PPO provider in a PPO hospital at the PPO benefit level. (see page 51)
- We clarified which services are payable at the PPO benefit level, when the services are rendered at a PPO hospital or ambulatory surgical center by non-PPO emergency room physicians, radiologists, pathologists, and anesthesiologists. (see page 28)
- We clarified what you pay for inpatient hospital services rendered by a CIGNA LIFESOURCE Transplant Network® provider. (see page 54)
- We clarified which mental health and substance abuse outpatient services need preauthorization. (see page 61)

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you become eligible for coverage. You should carry your ID card with you at all times. You must show it whenever you receive services from a provider or fill a prescription at an NALC CareSelect retail pharmacy. If you want to obtain a prescription at an NALC CareSelect retail pharmacy and have not received your identification card, call us at 703-729-4677 or 1-888-636-NALC (6252).

If you do not receive your ID card within 30 days after the effective date of your eligibility, or if you need replacement cards, call us at 703-729-4677 or 1-888-636-NALC (6252), or write to us at P.O. Box 678, Ashburn, VA 20146.

Where you get covered care

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

• Covered providers

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

- A licensed doctor of medicine (M.D.) or osteopathy (D.O.); or, for specified services covered by the Plan, a licensed dentist (D.D.S. or D.M.D.), podiatrist (D.P.M.), or chiropractor (D.C.).
- A nurse anesthetist (C.R.N.A.).
- A community mental health organization: A nonprofit organization or agency with a governing or advisory board representative of the community that provides comprehensive, consultative, and emergency services for treatment of mental conditions.
- A qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist, and nursing-school-administered clinic.
- 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 that are determined "medically underserved". For 2012, the states are: Alabama, Alaska, Arizona, Idaho, Illinois, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, Oklahoma, South Dakota, and Wyoming.

• Covered facilities

Covered facilities include:

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

- **Freestanding ambulatory facility:** An outpatient facility accredited by the Joint Commission, 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 1) 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*).
- **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. See *You need prior Plan approval for certain services,* in this Section.

What if I have a serious illness and my provider leaves the Plan?

Please contact us if you believe your condition is chronic or disabling. If it is, you may be able to continue seeing your provider for up to 90 days after you receive notice that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

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 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 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 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 1-866-512-3767.
  - 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 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 of inpatient admissions in these cases:

- You are admitted to a hospital outside the United States.
- You are covered under another group health insurance plan 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.

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 of radiology/imaging services 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.

- **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*. However, since there is no automatic reduction in benefits for failure to preauthorize DME benefits, claims involving DME are not pre-service claims under the claims and appeals procedures. See Section 8. *Claims and Appeals Procedures.*

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

Section 4. Your costs for covered services

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

Copayments

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

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

Cost-sharing

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. The family deductible is satisfied when the combined covered expenses applied to the calendar year deductible for family members total the amounts shown. Copayments and coinsurance amounts do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply counts toward the deductible. Your copayments, excluding prescription drugs, **do** count toward your out-of-pocket maximum.

- The 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.

Coinsurance

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

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

If your provider routinely waives your cost

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

For example, if your physician ordinarily charges $100 for a service but routinely waives your 30% coinsurance, the actual charge is $70. We will pay $49.00 (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 12.

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.

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.

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.

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

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

When you have Medicare prescription drug coverage (Part D)

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

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

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

Section 5. Benefits—OVERVIEW

(See page 15 for how our benefits changed this year and page 113 for a benefits summary.)

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The 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 cost-sharing. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **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 • Initial examination of a newborn child covered under a family enrollment • Inpatient medical consultations • Home visits Note: For routine post-operative surgical care, see Section 5(b). *Surgical procedures.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
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*

Benefit Description	You pay After calendar year deductible
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 • Routine office visit on the same day as a pap test • 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: • 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 and B vaccines—adults age 19 and older with medical indications as recommended by the CDC • 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 49 (except as provided for under *Preventive care, children* in this section) • 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)	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.)	
• 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
Note: When the NALC Health Benefit Plan for Employees and Staff 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—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	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.)	
• General health panel blood test—one annually • Gonorrhea screening limited to: - Women age 25 and younger - 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 • Human Papillomavirus (HPV)—one every three years, for women age 30 through 70 • 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 through 64 at increased risk as recommended by the U.S. Preventive Services Task Force (USPSTF) - Women age 65 and older • Pap test • 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 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 • Breast cancer chemoprevention • Depression • Obesity • 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*

Benefit Description	You pay After calendar year deductible
Preventive care, children	
• Examinations, limited to: - 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 - Meningococcal immunization—as recommended by the AAP Note: When the NALC Health Benefit Plan for Employees and Staff 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: - Chlamydial infection test - Gonorrhea screening—as recommended by the U.S. Preventive Services Task Force (USPSTF) - Hemoglobin/hematocrit—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 - 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 - 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)—limited to one, age 3 through 5 Note: For the coverage of the initial newborn exam see *Diagnostic and treatment services* in this section.	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.)	
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 Screening tests as recommended by the USPSTF for pregnant women, limited to: • Hepatitis B • Iron deficiency anemia • Rh screening • Syphilis • Urine culture for bacteria Preventive medicine counseling as recommended by the U.S. Preventive Services Task Force (USPSTF) for pregnant women, limited to: • Breastfeeding	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.)	
• 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 sterilization (see Section 5(b). *Surgical procedures*) • Implanted contraceptives • Insertion of intrauterine devices (IUDs)	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
• Injectable contraceptive drugs (such as Depo provera) • Diaphragms • Intrauterine devices Note: We cover oral contraceptives only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits*. Note: Intrauterine contraceptive devices purchased at a retail pharmacy or through the NALC mail order prescription drug program are covered only under the Prescription drug benefit. See Section 5(f). *Prescription drug benefits*.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Reversal of voluntary surgical sterilization, genetic counseling	*All charges*

Benefit Description	You pay After calendar year deductible
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 CVS 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 $1000 in a lifetime	PPO: 15% of the Plan allowance and all charges after we pay $1000 in a lifetime Non-PPO: 30% of the Plan allowance and all charges after we pay $1000 in a lifetime
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 examinations for amblyopia and strabismus, 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: • *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*

Benefit Description	You pay After calendar year deductible
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 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 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*

Benefit Description	You pay After calendar year deductible
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. Note: Call us at 703-729-4677 or 1-888-636-NALC (6252) as soon as your physician prescribes equipment or supplies. 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 • 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

Durable medical equipment (DME) – continued on next page

Benefit Description	You pay After calendar year deductible
Durable medical equipment (DME) (cont.)	
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 40*	*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: • *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 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.	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

Chiropractic – continued on next page

Benefit Description	You pay After calendar year deductible
Chiropractic (cont.)	
Limited to: • Initial office visit or consultation • 20 office visits per calendar year when rendered on the same day as a covered spinal 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*
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 cost-sharing. Also, read Section 9. *Coordinating benefits with other coverage*.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c). *Services provided by a hospital or other facility, and ambulance services*, for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL FOR ORGAN/TISSUE TRANSPLANTS**. See Section 5(b). *Organ/tissue transplants*.

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

Surgical procedures- continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone), except as listed in Section 5(g).* Dental benefits • *Cosmetic surgery, except for repair of accidental injury if repair is initiated within six months after an accident; correction of a congenital anomaly; or breast reconstruction following a mastectomy* • *Radial keratotomy and other refractive surgery* • *Procedures performed through the same incision deemed incidental to the total surgery, such as appendectomy, lysis of adhesion, puncture of ovarian cyst* • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standby surgeons are medically necessary* • *Cutting, trimming, or removal of corns, calluses, or the free edge of toenails; and similar routine treatment of conditions of the foot, except as listed under Section 5(a).* Foot care	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance; and - The condition can reasonably be expected to be corrected by such surgery	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)

Reconstructive surgery – continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
• 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*
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*

Benefit Description	You pay
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 • Pancreas	15% of the Plan allowance for services obtained through the CIGNA LIFESOURCE 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. • 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 LIFESOURCE 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.)	
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 osteopetrosis - 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 - 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	15% of the Plan allowance for services obtained through the CIGNA LIFESOURCE 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.)	
• 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 LIFESOURCE 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 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 LIFESOURCE 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 LIFESOURCE 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 LIFESOURCE Transplant Network®—The Plan participates in the CIGNA LIFESOURCE Transplant Network®. Before your initial evaluation as a potential candidate for a transplant procedure, you or your physician must contact CIGNA HealthCare at 1-800-668-9682 and speak to a referral specialist in the Comprehensive Transplant Case Management Unit. You will be given information about this program including a list of participating providers. Charges for services performed by a CIGNA LIFESOURCE Transplant Network® provider, whether incurred by the recipient or donor are paid at 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 LIFESOURCE Transplant Network®
Limited Benefits—If you do not obtain prior approval or do not use a designated facility, or if we are not the primary 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 LIFESOURCE 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*
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

Anesthesia – continued on next page

Benefit Description	You pay
Anesthesia (cont.)	
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)

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 cost- sharing. Also, read Section 9. *Coordinating benefits with other coverage*.
- 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, "(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 LIFESOURCE 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 LIFESOURCE 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 LIFESOURCE 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. 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.	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.)	
• Outpatient services and supplies for the delivery of a newborn	PPO: Nothing when services are related to the delivery of a newborn 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
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*

Benefit Description	You pay
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 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 cost-sharing. Also, read Section 9. *Coordinating benefits with other coverage*.

What is an accidental injury?

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

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 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 dental benefits for accidental injury, see Section 5(g). *Dental benefits.*	PPO: Nothing (No deductible) Non-PPO: The difference, if any, between the Plan allowance and the billed amount (No deductible)
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 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 cost-sharing. Also, read Section 9. *Coordinating benefits with other coverage*.
- **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 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 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
• 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* • *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: The Plan will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. We will generally not 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[SM] Behavioral Solutions insures and administers our mental health and substance abuse benefits. Call 1-866-512-3767 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 1-866-512-3767 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[SM] 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[SM] Behavioral Solutions P.O. Box 30755 Salt Lake City, UT 84130-0755 Questions? 1-866-512-3767 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[SM] 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 67.

- 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 cost-sharing. Also, read Section 9. *Coordinating benefits with other coverage*.

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

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

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

- **We use a formulary.** Our formulary is open and voluntary. If your physician believes a brand name drug is necessary, or if there is no generic available, ask your physician to prescribe a brand name drug from our formulary list. These preferred brand name drugs are selected to meet patient needs at a lower cost. To order the formulary pamphlet, call 1-800-933- NALC (6252).

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 CVS Caremark Specialty Pharmacy Services.
  - 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 CVS 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 CVS 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 CVS 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 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 • Contraceptive drugs and devices • 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 - Brand name: 30% 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 - Brand name: 20% 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 brand name • 90-day supply: $5 NALCSelect generic • 90-day supply: $7.99 NALCPreferred generic • 90-day supply: $12 generic/$65 brand name Mail order Medicare: • 60-day supply: $7 generic/$37 brand name • 90-day supply: $4 NALCSelect generic • 90-day supply: $4 NALCPreferred generic • 90-day supply: $10 generic/$55 brand name 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)	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
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 CVS 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 drugs for infertility* *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 cost-sharing. Also, read Section 9. *Coordinating benefits with other coverage.*

What is an accidental dental injury?

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

What is a sound natural tooth?

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

Benefit Description	You pay
Note: The calendar year deductible applies ONLY when we say, "(calendar year deductible applies)."	
Accidental dental injury benefit	
We only cover outpatient dental treatment incurred and completed within 72 hours of an accidental injury (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, coronary heart failure, chronic obstructive pulmonary disease, diabetes, and ulcers. Call Alere™ Health Management at 1-866-270-2202 for more information.

Special feature	Description
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.
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. Completion of the HRA is voluntary.
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.
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)
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.

Special feature	Description
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 6. General exclusions—things we don’t cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. 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, when the pregnancy is the result of an act of rape or incest, or where there is medical evidence, satisfactory to the Plan, of a non-survivable abnormality affecting the fetus and for health risk to the mother associated with carrying the pregnancy to term.
- 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 doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 25).
- 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) for autism.
- Transportation (other than professional ambulance services or travel under the CIGNA LIFESOURCE Transplant Network®).
- Dental services and supplies (except those oral surgical procedures listed in Section 5(b). *Oral and maxillofacial surgery* and Section 5(g). *Dental benefits*).
- Services for and/or related to procedures not listed as covered.
- Charges in excess of the Plan allowance.
- 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.

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).

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).

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 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

You will be notified of the determination on your claim within 30 days after your post-service claim is received. If matters beyond our control require an extension of time, it may take up to an additional 15 days for review and you will be notified before the expiration of the original 30-day period. The notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If an extension is needed because you did not provide necessary information, the notice will describe the specific information required and you will have up to 60 days from the receipt of the notice to provide the information.

If you do not agree with the initial decision, you may request review by following the appeals 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 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 for Employees and Staff
P.O. Box 678
Ashburn, VA 20146

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 within the deadline (we will inform you of the deadline when we ask for additional information). Our deadline for responding to your claim is suspended 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 procedure described in Section 8. *Claims and Appeal Procedures*). 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.

Section 8. Claim and appeal procedures

The steps you must take to file a claim are set forth in Section 7 of this brochure, *Filing a claim for covered services* (see also Section 3 and Section 5(e) for pre-service claims). The steps you must take to appeal a denial of a claim (whether a complete or partial denial) for benefits under the Plan or a retroactive termination of your coverage under the Plan are set forth below. These procedures apply to all claims filed on or after January 1, 2012. If you have any questions about these procedures, please feel free to call us at 703-729-4677 or 1-888-636-NALC (6252).

What is a claim?

A claim for benefits is a request for Plan benefits made in accordance with the Plan's claims procedures and requires submission of a written claim form. Simple inquiries about the Plan's provisions or eligibility that are unrelated to any specific benefit claim will not be treated as a claim for benefits under these procedures (except for **"Pre-Service Claims**" and **"Urgent Care Claims"** as described below). In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits. Retail and mail order pharmacy transactions are point-of-service transactions and are also not considered "claims for benefits" under these procedures.

Timeframes for deciding Pre-Service Claims and Urgent Care Claims

Claims for Inpatient hospital benefits, Organ/tissue transplants, Radiology/imaging services, Specialy Drugs, and Inpatient and Outpatient mental health conditions and substance abuse benefits, are all considered **Pre-Service Claims**. Pre-Service Claims are claims for benefits where the Plan requires you to obtain approval in advance of receiving the benefit as a condition of coverage. For further information about precertification and preapproval, please refer to Section 5(e) of this brochure for *Mental health and substance abuse benefits* and Section 3 of this brochure for all other benefits. If you follow the precertification procedures, you will be deemed to have filed a Pre-Service Claim in accordance with the Plan's procedures.

Certain claims that require precertification may be considered **Urgent Care Claims**. A request for precertification on an Urgent Care Claim involves any claim for medical care or treatment with respect to which the application of the time periods for making pre-service determinations (1) could seriously jeopardize your life or health or your ability to regain maximum function, or (2) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an Urgent Care Claim will be determined by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim shall be treated as an Urgent Care Claim.

Inpatient hospital benefits and Organ/tissue transplants

For claims for Inpatient hospital benefits, you must obtain precertification from CIGNA/CareAllies , as set forth in Section 3 of this brochure. You, your representative, your physician, or your hospital must call 1-877-220-NALC (6252).

For Organ/tissue transplants, you must contact CIGNA HealthCare at 1-800-668-9682 to enroll in the CIGNA LIFESOURCE Transplant Network®, as set forth on page 51 of this brochure.

The proposed service will be reviewed and evaluated to determine whether it is medically necessary. CIGNA/CareAllies will provide you and your providers with written notification advising whether your request for precertification was approved or denied. If the proposed services are determined not to be medically necessary and the precertification request is denied in whole or in part, the notice will describe why the proposed services were non-certified and will describe how to appeal the non-certification determination. Please see, *What to do if your claim for benefits or request for precertification is denied.*

For **Urgent Care Claims**, you and your doctor will receive a determination of your request for precertification by telephone as soon as possible taking into account the medical urgency, but not later than **72 hours** after receipt of the claim. The determination will also be confirmed in writing.

If you improperly file an Urgent Care Claim (i.e., you fail to follow certification procedures), you will be notified as soon as possible, but not later than **24 hours** after receipt of the request for precertification of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim for benefits under these procedures.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, you and your doctor will be notified as soon as possible, but not later than **24 hours** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within **48 hours**. If the information is not provided within that time, your claim will be denied. Notice of the decision will be provided no later than **48 hours** after receipt of the specified information.

For **Pre-Service Claims** that are not Urgent Care Claims, if you provide all the required information when you call to precertify, you will be notified in writing of the decision concerning your request for precertification within **15 days** of your call unless additional time is needed due to matters beyond the control of CIGNA/CareAllies. Under those circumstances, the time to decide your claim may be extended up to **15 days**. Prior to the expiration of the initial 15-day period, you will be notified of the circumstances necessitating the extension of time and the date on which a decision is expected to be made with respect to your claim. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you and/or your provider will have **45 days** from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period which you are provided to supply additional information, the 15-day period for making a decision on the claim will be suspended from the date of the extension notice until the earlier of (1) either **45 days** or (2) the date you respond to the request. A decision must then be made on your claim within **15 days** and you must be notified of the determination.

If you improperly file a claim for benefits for non-urgent care that requires precertification and the improperly filed claim includes (1) your name, (2) your specific medical condition or symptom, and (3) a specific treatment, service, or product for which approval is requested, you will be notified as soon as possible, but not later than **5 days** after receipt of your improperly filed claim, of the proper procedures to be followed in filing a claim. Notification may be oral; however, you will be sent written notification upon request.

Radiology/Imaging Services

For claims for outpatient radiology/imaging services, including CT/CAT – Computerized Axial Tomography, MRI – Magnetic Resonance Imaging, MRA – Magnetic Resonance Angiography, NC – Nuclear Cardiac Imaging Studies and PET scans – Positron Emission Tomography, you must obtain preauthorization by calling 1-877-220-NALC (6252) before scheduling the procedure. The preauthorization determination will be made by CIGNA/CareAllies or MedSolutions. If CIGNA/CareAllies or MedSolutions determines that the outpatient radiology/imaging service is not medically necessary, and the precertification request is denied, you and your physician will be notified of their determination.

For **Pre-Service Claims** involving non-urgent care, if you provide all the required information when you call to precertify, you will be notified in writing of the decision concerning your request for precertification within **15 days** of your call unless additional time is needed due to matters beyond the control of the reviewer. Under those circumstances, the reviewer may extend its time to decide your claim up to **15 days**. Prior to the expiration of the initial 15-day period, the reviewer will notify you of the circumstances necessitating the extension of time and the date on which the reviewer expects to make a decision with respect to your claim. If an extension is needed because the reviewer needs additional information from you, the extension notice will specify the information needed. In that case, you and/or your provider will have **45 days** from receipt of the notification to supply the additional information. If the information is not provided

within that time, your claim will be denied. During the 45-day period which you are provided to supply additional information, the 15-day period for making a decision on the claim will be suspended from the date of the extension notice until the earlier of (1) either **45 days** or (2) the date you respond to the request. The reviewer then has **15 days** to make a decision on your claim and to notify you of the determination denying the request for precertification in whole or in part.

If you improperly file a claim for benefits for non-urgent care that requires precertification and the improperly filed claim includes (1) your name, (2) your specific medical condition or symptom, and (3) a specific treatment, service, or product for which approval is requested, the reviewer will notify you as soon as possible, but not later than **5 days** after receipt of your improperly filed claim, of the proper procedures to be followed in filing a claim. This notification may be oral; however, a written notification will be sent if you request it.

Specialty Drugs

All specialty drugs require precertification 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. To obtain precertification , ~~C~~call CVS Caremark Specialty Pharmacy Services at 1-800-237-2767.

If CVS Caremark finds that the proposed drug is not medically necessary, and precertification is denied, you and your physician will be notified of CVS Caremark's determination. For information on how to appeal this determination, see *Claim and Appeal…What to do if your claim for benefits or request for precertification is denied.*

For **Urgent Care Claims**, CVS Caremark will respond to you and your doctor with a determination of your request for precertification by telephone as soon as possible taking into account the medical urgency, but not later than **72 hours** after receipt of the request for approval by CVS Caremark. The determination will also be confirmed in writing.

If you improperly file an Urgent Care Claim (i.e. you fail to follow precertification procedures), CVS Caremark will notify you as soon as possible, but not later than **24 hours** after receipt of the request for prior approval, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, CVS Caremark will notify you and your doctor as soon as possible, but not later than **24 hours** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within **48 hours**. If the information is not provided within that time, your claim will be denied. Notice of the decision will be provided no later than **48 hours** after CVS Caremark receives the specified information.

For **Pre-Service Claims** involving specialty drugs for which prior approval is required but that are not Urgent Care Claims, if you provide all the required information when you call CVS Caremark for preauthorization, CVS Caremark will notify you in writing of its decision concerning your request for preauthorization within **15 days** of your call unless additional time is needed due to matters beyond the control of CVS Caremark or the Plan. Under those circumstances, the time to decide your claim may be extended up to **15 days**. Prior to the expiration of the initial 15-day period, we will notify you of the circumstances necessitating the extension of time and the date on which a decision is expected to be made with respect to your claim. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you and/or your provider will have **45 days** from receipt of the

notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period which you are provided to supply additional information, the 15-day period for making a decision on the claim will be suspended from the date of the extension notice until the earlier of (1) either **45 days** or (2) the date you respond to the request. CVS Caremark then has **15 days** to make a decision on your claim and to notify you of the determination.

If you improperly file a claim for benefits for non-urgent care that requires preauthorization, provided that the improperly filed claim includes (1) your name, (2) your specific medical condition or symptom, and (3) a specific treatment, service or product for which approval is requested, CVS Caremark will notify you as soon as possible but not later than **5 days** after receipt of your improperly filed claim of the proper procedures to be followed in filing a claim. The notification may be oral; however, we will send you written notification upon request.

Inpatient and Outpatient Mental Health and Substance Abuse Benefits

For claims for Inpatient mental health and substance abuse and Outpatient mental health and substance abuse benefits, you must obtain precertification from OptumHealth℠ Behavioral Solutions, as set forth in *Section 5(e)* of this brochure. OptumHealth℠ Behavioral Solutions will review the proposed service and evaluate whether it is medically necessary. If it is determined to be medically necessary, you and your providers will be advised that the service is precertified. If OptumHealth℠ Behavioral Solutions determines that the proposed services are not medically necessary, you and your physician will be advised that the service is not precertified. The notice concerning a denial on a precertification request will describe why the proposed services were not certified and will describe how to appeal the denial of certification. Please also see in this section, *What to do if your claim for benefits or request for precertification is denied.*

Based on the type of request (Pre-Service Claim or Urgent Care Claim), OptumHealth℠ Behavioral Solutions will respond within the following timeframes. For Urgent Care Claims, OptumHealth℠ Behavioral Solutions will respond to you and your doctor with a determination of your Urgent Care Claim by telephone as soon as possible taking into account the medical urgency, but not later than **72 hours** after receipt of the claim by OptumHealth℠ Behavioral Solutions. The determination will also be confirmed in writing.

If you improperly file an Urgent Care Claim (i.e., you fail to follow certification procedures), OptumHealth℠ Behavioral Solutions will notify you as soon as possible, but not later than **24 hours** after receipt of the request for precertification, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, OptumHealth℠ Behavioral Solutions will notify you and your doctor as soon as possible, but not later than **24 hours** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within **48 hours**. If the information is not provided within that time, your claim will be denied. Notice of the decision will be provided no later than **48 hours** after OptumHealth℠ Behavioral Solutions receives the specified information.

For **Pre-Service Claims** involving non-urgent care, if you provide all the required information when you call OptumHealth℠ Behavioral Solutions to precertify, OptumHealth℠ Behavioral Solutions will notify you in writing of its decision concerning your request for precertification within **15 days** of your call unless additional time is needed due to matters beyond the control of OptumHealth℠ Behavioral Solutions. Under those circumstances, OptumHealth℠ Behavioral Solutions may extend its time to decide your claim up to **15 days**. Prior to the expiration of the initial 15-day period, OptumHealth℠ Behavioral Solutions will notify you of the circumstances necessitating the extension of time and the date on which OptumHealth℠ Behavioral Solutions expects to make a decision with respect to your claim. If an extension is needed because OptumHealth℠ Behavioral Solutions needs additional information from you, the extension notice will specify the information needed. In that case, you and/or your provider will have **45 days** from receipt of the notification to supply the additional information. If the information is not provided

within that time, your claim will be denied. During the 45-day period which you are provided to supply additional information, the 15-day period for making a decision on the claim will be suspended from the date of the extension notice until the earlier of (1) either **45 days** or (2) the date you respond to the request. OptumHealth[SM] Behavioral Solutions then has **15 days** to make a decision on your claim and to notify you of the determination.

If you improperly file a claim for benefits for non-urgent care that requires precertification and the improperly filed claim includes (1) your name, (2) your specific medical condition or symptom, and (3) a specific treatment, service or product for which approval is requested, OptumHealth[SM] Behavioral Solutions will notify you as soon as possible but not later than **5 days** after receipt of your improperly filed claim of the proper procedures to be followed in filing a claim.

Concurrent Care Claims

A Concurrent Care Claim occurs where an ongoing course of treatment was precertified and (1) the benefit is then reduced or terminated, or (2) you request an extension of the benefit. In this situation, the decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment. Notification of a termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made as soon as possible, but in any event, early enough to allow you to have an appeal decided before the benefit is reduced or terminated. Any request by you to extend approved care treatment for an Urgent Care Claim will be acted upon within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to the otherwise applicable timeframes.

Timeframes for deciding Post-Service Claims

Post-Service Claims are claims for benefits for which the Plan does not require precertification or approval in advance of receiving the services in order for the services to be covered, or claims that are filed after the treatment has been rendered, or the services received (in other words, claims that are not Urgent-Care Claims or Pre-Service Claims). For all Post-Service Claims, you will ordinarily be notified of the decision on your claim within **30 days** from the receipt of your claim for mental health and substance abuse benefits, notification will be made within **30 days** of receipt by OptumHealth[SM] Behavioral Solutions. This period may be extended one time for up to **15 days** if the extension is necessary due to matters beyond the control of the Plan (or OptumHealth[SM] Behavioral Solutions) provided that, prior to the expiration of the initial 30-day period, the Plan or (OptumHealth[SM] Behavioral Solutions) notifies you of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If an extension is needed because the Plan (or OptumHealth[SM] Behavioral Solutions) needs additional information from you, the extension notice will specify the information needed. In that case, you will have **45 days** from your receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period you are given to supply additional information, the 30-day period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until the earlier of (1) **45 days** or (2) until the date you respond to the request. The Plan (or OptumHealth[SM] Behavioral Solutions) then has **15 days** to decide your claim and notify you of the determination.

Notice of decision

You will be provided written notice of a denial of a claim. This notice will state:

- The specific reason(s) for the determination
- Reference to the specific Plan provision(s) on which the determination is based
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary
- A description of the appeal and external review procedures and applicable time limits
- A statement of your right to bring a lawsuit under ERISA following an adverse benefit determination on review
- If an internal rule, guideline, or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that is available upon request at no charge
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that is available upon request at no charge.

What to do if your claim for benefits or request for precertification is denied

The procedures for appealing a claim that is denied in whole or in part differ depending on the type of claim involved (urgent-care, pre-service or post-service). The different appeal procedures are set forth below. Except as indicated below, all appeals must be in writing. All appeals must include the patient's name, member's name and identification number, date(s) of service and the name of the provider and must indicate the grounds on which the appeal is being made. You may include any information you would like to be considered. You or your authorized representative may review pertinent documents and submit issues and comments in writing for consideration by the Plan.

You should check with your provider or facility to be sure that the claim was filed correctly. For instance, did the provider use the correct procedure code for the services performed (surgery, laboratory test, x-ray, office visit, etc.)? Have your provider indicate any complications of any surgical procedures performed. Your provider should also include copies of an operative or procedure report or other documentation that supports your claim.

Appeals of denials of Urgent Care Claims

If your Urgent Care Claim requesting precertification of **Inpatient hospital benefits, Organ/tissue transplant benefits or Radiology/imaging benefits** is denied in whole or in part, you, your designated authorized representative, or your health care provider may request a review of the denial by CIGNA/CareAllies (or MedSolutions, if MedSolutions issued the denial of precertification for Radiology/imaging benefits). Your request must be submitted within one hundred eighty (180) days of your receipt of the notice of the claim denial or non-certification. Appeals concerning Urgent Care Claims may be made orally or in writing. Note that oral appeals are accepted for Urgent Care Claims only — all other appeals must be in writing. For an oral appeal on an Urgent Care Claim involving **Inpatient hospital benefits** or **Organ/tissue transplant benefits**, or an Urgent Care Claim involving **Radiology/imaging benefits** where the precertification denial was issued by CIGNA/CareAllies, call CIGNA/CareAllies at 1-800-232-7497 or write to Blue Bell Health Facilitation Center Site Lead, Attention: Appeals, 1777 Sentry Park West, Dublin Hall, Suite 400, 4th Floor, Blue Bell, PA 19422. For an Urgent Care Claim involving **Radiology/imaging benefits** where the precertification denial was issued by MedSolutions, submit your request to: MedSolutions, Inc., Attn: Appeals, 730 Cool Springs Blvd., Suite 800, Franklin, TN 37067. You will be notified of the final decision on the appeal within a reasonable time period, but not later than **72 hours** from receipt of the appeal request.

If you are not satisfied with the first level appeal decision on an Urgent Care Claim involving a request for precertification of **Inpatient hospital benefits, Organ/tissue transplant benefits** or **Radiology/imaging benefits,** you or your designated authorized representative may request a voluntary second level expedited appeal review by CIGNA/CareAllies as applicable. This review will be completed within 72 hours of receipt of your request (if you continue to meet the expedited criteria). Your request must be sent to CIGNA/CareAllies at the address listed above, within no later than 180 days of the date of the notification of the decision on the initial appeal. The second level voluntary appeal will be reviewed by physician reviewer(s) who was(were) not involved in any prior review of your request.

If your Urgent Care Claim requesting preapproval of **Specialty drugs** is denied in whole or in part, you, your designated authorized representative, or your health care provider may request a review of CVS Caremark's denial. Your request must be submitted within 180 days of your receipt of the notice of the denial. Appeals concerning Urgent Care Claims may be made orally or in writing. Note that oral appeals are accepted for Urgent Care Claims only— all other appeals must be in writing. For an oral appeal on an Urgent Care Claim involving Specialty drugs, call the CVS Caremark Customer Care number1-888-636-NALC (6252). Written requests for review should be sent to Prescription Claim Appeals MC 109, CVS Caremark, P.O. Box 52084, Phoenix, AZ 85072-2084, or fax to 1-866-689-3092. You will be notified of the final decision on the appeal within a reasonable time period, but not later than **72 hours** from receipt of the appeal request.

If your Urgent Care Claim requesting precertification of **Inpatient mental health and substance abuse benefits or Outpatient mental health and substance abuse benefits** is denied in whole or in part, you, your designated authorized representative, or your health care provider may request a review of the denial. Your request must be submitted within 180 days of your receipt of the notice of the claim denial or non-certification. Appeals concerning Urgent Care Claims may be made orally or in writing. Note that oral appeals are accepted for Urgent Care Claims only — all other

appeals must be in writing. For an oral appeal on an Urgent Care Claim, call OptumHealth[SM] Behavioral Solutions at 1-800-548-6549 extension 3929. Written requests for review should be sent to OptumHealth[SM] Behavioral Solutions, Appeals Department, 100 East Penn Square, Ste. 400, Philadelphia, PA 19107, or fax to 1-888-881-7453. Your appeal should include your name and ID number, the date(s) of service(s), your treating providers' name and any information or documents you would like considered. The appeal will be reviewed, a decision made, and you or your provider notified of the decision within a reasonable time period, but not later than **72 hours** from OptumHealth[SM] Behavioral Solutions' receipt of the appeal request. You or your designated authorized representative will be notified of the final decision on the appeal within a reasonable time period, but not later than **72 hours** from OptumHealth[SM] Behavioral Solutions' receipt of the appeal request.

Appeals of denials of Pre-Service Claims (Non Urgent Care Claims)

If your Pre-Service Claim requesting precertification of **Inpatient hospital benefits, Organ/tissue transplant benefits,** or **Radiology/imaging services** are denied in whole or in part, you or your designated authorized representative may request a review of the denial. Your request must be in writing and submitted **180 days** of your receipt of the notice of the claim denial or non-certification. Written requests for review of denials of Inpatient hospital benefits, Organ/tissue transplants or Radiology/imaging services (where the precertification was reviewed by CIGNA/CareAllies) should be sent to CIGNA/CareAllies c/o Blue Bell Health Facilitation Center Site Lead, Attention: Appeals, 1777 Sentry Park West, Dublin Hall, Suite 400, 4th Floor, Blue Bell, PA 19422. Requests for review of denials of requests for precertification of Radiology/imaging services issued by MedSolutions should be sent to MedSolutions, Inc., Attn: Appeals, 730 Cool Springs Blvd., Suite 800, Franklin, TN 37067. You or your designated authorized representative will be sent a notice of the decision on appeal within **30 days** of CIGNA/CareAllies' (or MedSolutions', as appropriate) receipt of your appeal.

If you are not satisfied with CIGNA/CareAllies' or MedSolutions' first level appeal decision, you or your designated authorized representative have the right to request a second level appeal to CIGNA/CareAllies (NOTE: CIGNA/CareAllies will review all second level appeals for Radiology/imaging services, even if MedSolutions issued the initial appeal determination). For second level appeals to CIGNA/CareAllies, submit your request to CIGNA/CareAllies c/o Blue Bell Health Facilitation Center Site Lead, Attention: Appeals, 1777 Sentry Park West, Dublin Hall, Suite 400, 4th Floor, Blue Bell, PA 19422. The second level appeal request must be submitted within **180 days** from your receipt of the first level appeal decision. You or your designated representative will be notified of the decision within **15 days** of receipt of your request for review of the first level appeal decision.

If your Pre-Service Claim requesting preapproval of **Specialty drugs** is denied in whole or in part, you or your designated authorized representative may request a review of the Plan's denial by CVS Caremark. Your request must be in writing and submitted within **180 days** of your receipt of the notice of the denial, together with any documentation to support your appeal. Written requests for review should be sent to Prescription Claim Appeals, MC 109, CVS Caremark, P.O. Box 52084, Phoenix, AZ 85072-2084, or fax to 1-866-689-3092. You or your designated authorized representative will be notified of the final decision on the appeal within a reasonable time period, but not later than **30 days** from receipt of the appeal request and complete information.

If your Pre-Service Claim requesting precertification of **Inpatient mental health and substance abuse benefits** or **Outpatient mental health and substance abuse benefits** is denied in whole or in part, you or your designated authorized representative may request a review of the denial. Your request must be in writing and submitted within **180 days** of your receipt of the notice of the claim denial or non-certification. Written request for review should be sent to OptumHealth[SM] Behavioral Solutions, Appeals Department, 100 East Penn Square, Ste. 400, Philadelphia, PA 19107, or fax to 1-888-881-7453. You or your designated authorized representative will be sent a notice of OptumHealth[SM] Behavioral Solutions' decision on the first level of appeal within **15 days** of OptumHealth[SM] Behavioral Solutions' receipt of your appeal.

If you are not satisfied with the first level appeal decision, you or your designated authorized representative have the right to request a second level appeal to OptumHealth[SM] Behavioral Solutions. The second level appeal request must be submitted to OptumHealth[SM] Behavioral Solutions at the address listed above within **180 days** from your receipt of the first level appeal

decision. The second level appeal will be conducted and you or your designated authorized representative will be notified of the decision within **15 days** of OptumHealth[SM] Behavioral Solutions' receipt of your request for review of the first level appeal decision.

Appeals of denials of Post-Service Claims

If your Post-Service Claim **for any benefit other than Inpatient mental health and substance abuse benefits or Outpatient mental health and substance abuse benefits** is denied, you or your designated authorized representative may request a review by the Plan's Administrator. Your request must be in writing and must be submitted within **180 days** after your receipt of the Plan's written notice of denial. Requests for review must be sent to the Plan's Assistant Administrator at the following address: NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146. The Plan Administrator may confer with the Board of Trustees in reviewing your appeal. You or your designated authorized representative will be sent a notice of the decision on the appeal within **60 days** of the Plan's receipt of the appeal.

If your Post-Service Claim for **Inpatient mental health and substance abuse benefits** or **Outpatient mental health and substance abuse benefits** is denied in whole or in part, you or your designated authorized representative may request a review of the denial. Your request must be in writing and submitted within **180 days** of your receipt of the notice of the claim denial. Written request for review should be sent to OptumHealth[SM] Behavioral Solutions, Appeals Department, 100 East Penn Square, Ste. 400, Philadelphia, PA, 19107, or fax to 1-888-831-7453. You or your designated authorized representative will be sent a notice of OptumHealth[SM] Behavioral Solutions' decision on the first level of appeal within **30 days** of OptumHealth[SM] Behavioral Solutions receipt of your appeal.

If you are not satisfied with the first level appeal decision, you or your designated authorized representative have the right to request a second level appeal to OptumHealth[SM] Behavioral Solutions. The second level appeal request must be submitted to OptumHealth[SM] Behavioral Solutions at the address listed above within **180 days** from your receipt of the first level appeal decision. The second level appeal will be conducted and you or your designated authorized representative will be notified of the decision within **30 days** of OptumHealth[SM] Behavioral Solutions receipt of your request of the first level appeal decision.

If you are not satisfied with the second level appeal decision, you or your designated authorized representative may request a voluntary review by the Plan's Assistant Administrator. Your request must be in writing and must be submitted within **180 days** after your receipt of the Plan's written notice of denial. Requests for review must be sent to the Plan's Assistant Administrator at the following address: NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146. The Plan's Assistant Administrator may confer with the Plan's Administrator and/or Board of Trustees of the Plan in reviewing your appeal. You or your designated authorized representative will be sent a notice of the decision on the appeal within **60 days** of the Plan's receipt of the appeal.

Appeals of Rescissions of Coverage

A "rescission" is a cancellation or termination of coverage that has retroactive effect. You can appeal a rescission of your coverage regardless of whether the rescission has an adverse effect on any particular benefit or claim at the time it occurs. In other words, if the Plan determines that your coverage under the Plan, or your dependent's coverage under the Plan must be terminated, *and* that the termination is retroactive, you can appeal even if no claims for benefits are denied as as a result of the rescission. If your coverage under the Plan is rescinded, you or your designated authorized representative may request a review by the Plan Administrator. Your request must be in writing and submitted within **180 days** after your receipt of the Plan's written notice of the retroactive termination or cancellation of coverage. Request for review must be sent to the Plan's Assistant Administrator at the following address: NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146. The Plan Administrator may confer with the Plan's Board of Trustees in reviewing your appeal. You or your designated authorized representative will be sent a notice of the decision on the appeal within **60 days** of the Plan's receipt of the appeal.

Right to review documents and to obtain other information

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan (or its designee) in making the decision: it was submitted, considered or generated (regardless of whether it was relied upon), it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision making, or it constitutes a statement of the Plan's policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical experts, if any, that advised the Plan concerning your claim, without regard to whether the advice was relied upon in deciding your claim.

Right to independent review

A different reviewer will consider your appeal other than the reviewer who originally denied the claim. The reviewer on appeal will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that you submit.

Cases involving a medical judgment

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Notice of the determination of your appeal

The decision on your appeal will be in writing and will include the following information:

- The specific reason(s) for the determination
- Reference to the specific Plan provisions on which the determination is based
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge
- A statement regarding any available external review process
- A statement of your right to bring a lawsuit under ERISA Section 502(a) following an adverse benefit determination on review
- If an internal rule, guideline, or protocol was relied upon in deciding the appeal, you will receive either a copy of the rule or a statement that it is available upon request at no charge
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Final review

The decision upon final review will be final and binding on all parties, subject to any rights you may have to external review and to sue in Federal court. If you sue in Federal court, the decision upon review is entitled to deference in by the court to the fullest extent allowed by applicable law. In the event the initial adverse determination is upheld and you decide to seek judicial review, no suit may be filed later than December 31 of the third year after the year in which the care or service was provided. For claims involving Mental Health or Substance Abuse benefits, you may not sue after three years from the time proof of loss is required, unless the law in the area where you live allows for a longer period of time and any suit must be brought against OptumHealth[SM] Behavioral Solutions. Note, however, that you may not sue on a claim for benefits unless and until you have exhausted the appeals procedures set forth above.

Designated authorized representative

You may submit a claim and appeal a denial of a claim on your own behalf. Alternatively, you may designate another individual, including a health care provider, to act as your representative. If you choose to designate someone else to act on your behalf, you must inform the Plan in writing. If you revoke your designation of an authorized representative, the revocation will not be effective until written notice is received by the Plan (or, for mental health and substance abuse benefits, OptumHealth[SM] Behavioral Solutions). However, for Urgent Care Claims, the Plan (or, for mental health and substance abuse benefits, OptumHealth[SM] Behavioral Solutions) will permit a doctor or other health care professional who has knowledge of your medical condition to act as your authorized representative in the absence of a written designation. Once you have designated an authorized representative, all communication and notices from the Plan (or, for mental health and substance abuse benefits, OptumHealth[SM] Behavioral Solutions) that would otherwise be sent to you will only be sent to your authorized representative, unless you advise the Plan (or OptumHealth[SM] Behavioral Solutions) to the contrary.

External Review of Appeals

For certain types of claims, if your appeal is denied (or deemed denied if appeal procedures were not followed), you may request external review of the decision by an Independent Review Organization (IRO). You will receive additional information concerning the process for external review by an IRO, if available, with the notice of final internal determination on your appeal.

Your request for external review must be filed within four months after the date you receive notice of the decision to deny your claim. A preliminary review will be conducted and you will be notified within 5 business days whether you are eligible for external review, or whether more information or materials are needed from you to make the decision. If more information or materials are needed, you will have until the later of the end of the four-month period that began on the day you received notice of the claim denial or within the 48-hour period following the day you were notified that more information or materials were required.

If your claim is accepted for external review, the IRO will notify you. You will then have 10 business days to provide the IRO with any additional information you want it to consider. The IRO is not required to accept any information from you more than 10 business days after you receive notice, but it may decide to do so. The Plan (or other reviewer) will have 5 business days after your claim is assigned to an IRO within which to provide the IRO with all the documents and information to be considered in reviewing your claim. If the Plan (or other reviewer) fails to do so, the IRO may decide to reverse the benefit denial, in which case it will notify you and the Plan within one business day after making this decision. The IRO will forward to the Plan (or other reviewer) any information you provide. The Plan (or other reviewer) may then decide to reverse its denial, in which case you will be notified within 1 business day of such a decision.

If the denial of your claim is not reversed as described in the paragraph above, the IRO will provide you and the Plan with written notice of its decision on your claim within 45 days after it receives the request for external review. The IRO is not bound by the prior internal decision or conclusions regarding your claim. The notice will contain:

- A description of the reason for the request for external review;
- The date the IRO received the request for review;
- References to the evidence and documentation used in reviewing the claim;
- A discussion of the reason(s) for the decision;
- A statement that the IRO's decision is binding except to the extent other remedies are available under State or Federal law; and
- A statement that judicial review of the decision may be available to you.

If the IRO reverses the denial of benefits, the Plan (or, for mental health and substance abuse benefits, OptumHealth[SM] Behavioral Solutions) must immediately provide coverage or payment for the claim upon notification of the reversal.

The IRO must maintain records of your claim for six years and make the records available to you for inspection on your request.

Expedited External Review

You are entitled to request an expedited external review without first completing all of the appeals outlined above if you want to appeal an Urgent Care Claim after the initial denial if the claim involves a medical condition for which the time frame for internal appeal would seriously jeopardize your life or health or your ability to regain maximum function. You are entitled to request an expedited internal review even if your appeal on the claim was denied. If your appeal on the claim was denied at all levels, or if it was deemed denied, you are entitled to expedited review not only if the claim involves a medical condition for which the time frame for internal appeal would seriously jeopardize your life or health or your ability to regain maximum function, but also if the claim concerns an inpatient admission, availability of care, or continued stay for which you have received emergency services and have not been discharged from a facility.

Once you request an expedited external review, your request will be promptly reviewed to determine whether your request is eligible for expedited external review. You will be promptly provided notice of decision as to whether expedited external review is available or whether more information or materials from you are needed. If your request is eligible for expedited external

review, the claim will be assigned to an IRO and the IRO will be provided all documents and information considered in denying the claim. The IRO must make a decision no later than 72 hours after it receives the request. If the IRO does not initially notify you of its determination in writing, the IRO must provide written confirmation to you within 48 hours after providing the initial notice.

Please submit your request for an expedited external review to CIGNA/CareAllies for inpatient hospital and organ/tissue transplant claims. CIGNA/CareAllies or MedSolutions, as appropriate, for Radiology/imaging claims. CVS Caremark for specialty drug claims and OptumHealth℠ Behavioral Solutions for Inpatient or Outpatient mental health and substance abuse benefit claims, using the contact information under *Appeals of Urgent Care Claims*, in this Section.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary 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 guidelines.

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.

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 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 90.
- 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 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 Plan.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most people 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 Plan, which can help keep premiums down.

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

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

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

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

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 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 the 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 Medicare Advantage: You may enroll in Medicare Advantage plan and also remain enrolled in our 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.

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

Medicare always makes the final determination as to whether they are the primary 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 NALC Health Benefit Plan for Employees and Staff coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have NALC Health Benefit Plan for Employees and Staff coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
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 **(30-month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you…		
1) Have NALC Health Benefit Plan for Employees and Staff coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have NALC Health Benefit Plan for Employees and Staff coverage on your own as an annuitant or through a family member who is an annuitant	✓	

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.

Workers' Compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury that any medical benefits are payable for under workers' compensation or similar Federal or State laws, regardless of whether or not medical benefits have been applied for or paid under workers' compensation or similar provisions. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim (or potential claim) under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by workers' compensation for benefits paid by the Plan that were later found to be payable by workers' compensation or a similar agency.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

Subrogation/Reimbursement guidelines: 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.

Clinical Trials

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.

Section 10. Eligibility

Who is eligible for coverage?

All Employees as defined on page 106 are automatically eligible for coverage under the Plan effective on the first day in pay and duty status. Employees with eligible dependents are eligible for Self and Family coverage. Continued coverage is subject to the timely payment of your share of premiums.

Your eligible dependents are your legal spouse and any child under age 26 who is your biological child, your legally adopted child (or child placed with you pending adoption), your stepchild, or your eligible foster child. An "eligible foster child" means an individual who is placed with you by an authorized placement agency or under the terms of a court order. Spouses or children of your adult or minor child are not eligible dependents, except that your grandchildren up to age 26 may be eligible dependents if they live with you in a regular parent child relationship and you provide them with financial support. The determination whether a grandchild is eligible is made by the Staff Plan.

We may ask for documentation of your relationship to the child to verify eligibility for coverage, such as your child's birth certificate, final decree of adoption issued by the court (or a letter of placement by an adoption agency during the period before the adoption becomes final), marriage certificate between you and a stepchild's spouse, or proof that a child was placed under your supervision in foster care by a governing authority. Evidence of residency and financial support will be required if you wish to enroll a grandchild as your dependent.

An unmarried child age 26 or over who is incapable of self-support because of physical or mental disability existing before the child's 26th birthday also may be eligible for coverage as a dependent. See *Applying for Coverage for Disabled Adult Children* in this Section for additional information.

In the event that both parents of an eligible dependent child are Employees covered by the Staff Plan, that child may be enrolled as the dependent of one of the Employees, but not both. A child for whom you are required to provide health coverage pursuant to a Qualified Medical Child Support Order (QMCSO) will also be an eligible dependent, provided the QMCSO meets certain legal requirements. See *Qualified Medical Child Support Orders (QMCSO)* in this Section for additional information.

Applying for Coverage for Disabled Adult Children

You may enroll an unmarried child who is age 26 or older in Self and Family coverage if the child is incapable of self-support as a result of a physical or mental disability that existed before he or she reached age 26. Your child may be considered to be incapable of self-support only if his or her physical or mental disability is expected to continue for at least one year and, because of the disability, he or she is not capable of working at a self-supporting job. In addition, the child must be dependent upon your financial support.

A determination that a child is incapable of self-support will be made by the Staff Plan based upon a review of health care records and information concerning your financial support and income, if any, earned by your child. The Staff Plan may also require that your child undergo an examination by a qualified health care professional. If approved for coverage, the Staff Plan may re-evaluate your child's status periodically to determine if he or she has recovered from the disability.

You must apply for a determination prior to the time your child reaches age 26.

Open Enrollment

There is an annual Open Enrollment period from December 1 through December 31 during which active Employees may request changes in their enrollment status or cancel their enrollment. The changes made during the Open Enrollment period will be effective the following January 1. If you are an active or retired Employee and you wish to cancel your coverage under this Plan, you may cancel your coverage under this Plan at any time with advance written notice to the Plan. Active Employees who voluntarily cancel their coverage under this Plan for any reason may not reenroll until the next Open Enrollment period, except under certain limited circumstances. See *Special Enrollment* below. Retired Employees who voluntarily cancel their coverage under this Plan for

any reason may not reenroll. The coverage will be cancelled on the last day of the month following the date a completed request for the cancellation of the enrollment is received.

Active Employees who previously declined coverage under the Plan may enroll during the Open Enrollment period. Retired Employees who decline coverage under this Plan may not subsequently enroll in the Plan.

Please contact the Nongroup Department at 703-729-4677 or 1-888-636-NALC (6252) for additional information.

Special Enrollment

Loss of other health insurance coverage

If you are an active Employee eligible to participate in the NALC Health Benefit Plan for Employees and Staff and you or your eligible dependent(s) previously declined enrollment in the Plan because of other health insurance coverage, you may be able to enroll yourself or your eligible dependent(s) prior to the next Open Enrollment period if the other coverage is lost. If you or your eligible dependent(s) had COBRA coverage under another plan at the time you declined coverage and that coverage has now been exhausted, you may request that you and your eligible dependent(s) be enrolled in our Plan. In addition, if you or your eligible dependent(s) had other coverage (not COBRA coverage) at the time you declined enrollment and the other coverage is terminated either because of a loss of eligibility for coverage (due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment) or because the other employer stopped contributing for the other coverage, you may request that you and/or your eligible dependent(s) be enrolled in the Plan. In either case, requests for enrollment must be in writing and sent to the Plan (with a copy to your Employer) within 30 days after the other coverage is terminated or employer contributions towards the other coverage are terminated. If a completed request for enrollment is received within the 30-day period, you and your eligible dependent(s) will be enrolled in the Plan as of the first day of the month following the date a completed request for enrollment is received.

If you are a retired employee who is a spouse covered under another retired employee's enrollment in the NALC Health Benefit Plan for Employees and Staff, and lose coverage due to death, divorce or legal separation, you may request to enroll yourself in a Self Only enrollment within 30 days of the event. The coverage will be effective on the first day of the month following the date a completed request for enrollment is received.

Acquiring new dependents

If you are an active Employee eligible to participate in the Plan and you previously declined enrollment in the Plan for any reason, and you have now acquired a new eligible dependent (as defined in this Section) through marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself in the Plan without waiting until the next Open Enrollment period. In order to enroll yourself in the Plan under these circumstances, send a written request for enrollment to the Plan (with a copy to your Employer) within 30 days of the date of the marriage, birth, adoption, or placement for adoption.

If you are either an active or a retired Employee who participates in the Plan and you acquire a new spouse or a new eligible dependent through birth, adoption, or placement for adoption, you may be able to enroll your new spouse or eligible dependent in the Plan. In order to enroll under these circumstances, send a written request for enrollment to the Plan (with a copy to your Employer) within 30 days of your acquisition of the new dependent (that is, the date of the marriage, birth, adoption, or placement for adoption). In the case of a marriage, the Plan coverage for your new spouse will be effective on the first day of the month following the date a completed request for enrollment is received. In the case of a birth, adoption, or placement for adoption for your new child, the Plan coverage for your child will be effective on the date of the birth, adoption, or placement for adoption.

Qualified Medical Child Support Orders (QMCSO)

According to Federal law, a Qualified Medical Child Support Order (QMCSO), is a child support order of a court or state administrative agency that usually results from a divorce or legal separation, which has been received by the Plan and which: 1) designates one parent to pay for a child's health plan coverage; 2) indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO; 3) contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined; 4) states the period for which the QMCSO applies; and 5) identifies each health care plan to which the QMCSO applies.

"Child" for purposes of a QMCSO means the participant's natural (biological) or adopted child or a child placed with the participant for adoption. It does not include a stepchild.

If a court or state administrative agency has issued an order for health care coverage for any of the Employee's dependent children, the Plan Administrator or a designee will determine if that order is a QMCSO as defined by Federal law, and that determination will be binding on the employee, the other parent, the child, and any other party acting on behalf of the child. If an order is determined to be a QMCSO, and if the Employee is covered by the Plan, the Plan Administrator or its designee will so notify the parents and each child, and advise them of the Plan's procedures that must be followed to provide coverage of the dependent child(ren). Coverage of the dependent child(ren) will be subject to all terms and provisions of the Plan, to the extent permitted by applicable law. Coverage of a dependent child under a QMCSO will terminate when coverage of the enrollee-parent terminates for any reason, subject to the dependent child's right to elect COBRA Continuation Coverage if that right applies. Please contact the Plan for additional information or to request a copy of the Plan's QMCSO procedures.

Information for new members

Identification cards

We will send you an Identification (ID) card when you become eligible for coverage.

Pre-existing conditions

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

When you lose benefits

When is my coverage terminated?

Eligibility for benefits ends when (a) employment with the Employer stops, except when you retire and your coverage under the Plan continues in retirement; (b) you no longer meet the definition of an Employee. See Section 12. *Definitions of terms we use in this brochure*; or (c) on completion of one year on approved leave without pay, if applicable; or (d) you fail to pay the required premium for coverage under this Plan. A dependent is no longer eligible under your enrollment and is not otherwise eligible for the Plan's coverage when your coverage stops or when they are no longer eligible dependents under the rules of this Plan (e.g., because of your divorce, a child who reaches age 26, or in the case of a disabled child over age 26, on the date the child becomes capable of self-support), whichever comes first.

An additional 31 days of coverage will be provided, without an additional cost to the enrollee, when:

- Your eligibility/enrollment ends (except if you voluntarily cancel your enrollment or fail to pay the required premium for coverage); or
- You are a family member no longer eligible for coverage.

Retroactive Terminations

Where we determine termination of coverage is appropriate, we reserve the right to do so retroactively except where retroactive termination is not permitted under applicable law. Retroactive termination is permitted, for example, where we discover that there has been fraud or an intentional misrepresentation of a material fact regarding coverage under the Plan. Retroactive termination may also apply where a required premium has not been paid.

What happens if my enrollment in this Plan or my spouse's and/or dependent's eligibility ends?

Coverage upon termination of employment or other qualifying event(s) may be continued on a self-pay basis under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), P.L. 99-272, as amended subject to certain restrictions for a limited period of time. See Section 11. *COBRA Continuation Coverage*.

If an active Employee dies while enrolled in this Plan, the active Employee's surviving spouse and/or dependent(s) who were covered under the Employee's family enrollment in the Plan as of the date of the Employee's death will continue to be eligible for coverage under the Plan for up to 36 months after coverage would otherwise be lost following the Employee's death, subject to continued, timely payment of the Employee's share of the premium. Coverage shall be extended, subject to the continued timely payment of the Employee's share of the premium, for up to a maximum of 36 months following the date coverage would otherwise cease following the Employee's death except that, where a surviving dependent child attains age 26, that child's coverage shall cease upon the attainment of age 26 (subject to the child's right to continued coverage on a self-pay basis under COBRA). This survivor spouse and/or dependent(s) coverage is provided at the same, subsidized premium rate as the Employee was paying at the time of death, subject to any increases or decreases in the Employee premium share that apply to similarly situated active Employees during the 36-month period. This survivor spouse and/or dependent(s) coverage is supplemental coverage provided in lieu of COBRA continuation coverage as described in Section 11. *COBRA Continuation Coverage*, except where a separate intervening event would give rise to COBRA coverage (such as a child attaining age 26 during the applicable 36-month period).

Section 11. COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, a Federal law more commonly known as COBRA, provides that you and/or your family can continue health care coverage on a temporary basis in certain instances where coverage under the Plan would otherwise end. In order to continue health coverage under COBRA, you or your dependents are required to pay the full cost for such coverage during the continuation period. If you elect coverage, you will receive the same coverage as is provided by the Plan to similarly situated employees.

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This section generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect your right to receive it. The Internal Revenue Service (IRS) has issued a notice (Notice 98-12), in questions and answer format, to assist employees and their families in determining whether to elect COBRA continuation coverage. These questions and answers are available at the IRS Web site (http://www.irs.ustreas.gov) and at the Department of Labor (DOL) Web site (http://www.dol.gov/dol/ebsa). Copies of the Notice are also available upon request from the Plan.

The Plan Administrator is Fredric V. Rolando, National Association of Letter Carriers, 100 Indiana Avenue, N.W., Washington, DC 20001, phone number (202) 393-4695. COBRA continuation coverage for the Plan is administered by the, Assistant Administrator, NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146, phone number (703) 729-4677 or 1-888-636-NALC (6252).

You may want to consider electing COBRA so that you do not have more than a 63-day break between the termination of your coverage under this Plan and your coverage under another plan. An extended break in coverage may affect your rights or your ability to get coverage under another plan. See *Certificates of Creditable Coverage* in this Section for more details.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed later in this Section. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary", described more fully below. You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Qualifying events

COBRA continuation coverage is available should the occurrence of any of the following events result in your loss of coverage under the Plan:

- Termination of the Employee's employment (for reasons other than gross misconduct) or reduction in hours of employment
- Death of an Employee**
- An Employee becomes entitled to Medicare
- An Employee and his or her spouse become divorced
- Your child ceases to be an eligible dependent (e.g., due to reaching the age limitation)

** Supplemental continued coverage may be available in lieu of COBRA for a surviving spouse and/or dependent(s) upon the employee's death. See Section 10. *Eligibility – What happens if my enrollment in this Plan or my, spouse's and/or dependent's eligibility ends?*

Qualified beneficiaries

A Qualified beneficiary is someone who will lose coverage under the Plan because of a Qualifying event. Depending on the type of Qualifying event, Employees, spouses of Employees and dependent children of Employees may be Qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a Qualified beneficiary if you lose your coverage under the Plan because either one of the following Qualifying events happens: (1) your hours of employment are reduced, or (2) your employment ends for any reason other than your gross misconduct.

If you are the spouse of an Employee, you will become a Qualified beneficiary if you lose your coverage under the Plan because any of the following Qualifying events happens: (1) your spouse dies; (2) your spouse's hours of employment are reduced; (3) your spouse's employment ends for any reason other than his or her gross misconduct; (4) your spouse becomes entitled to Medicare

(Part A, Part B, or both); or (5) you become divorced from your spouse.

Your dependent children will become Qualified beneficiaries if they lose coverage under the Plan because any of the following Qualifying events happens: (1) the parent-Employee dies; (2) the parent-Employee's hours of employment are reduced; (3) the parent-Employee's employment ends for any reason other than his or her gross misconduct; (4) the parent-Employee becomes entitled to Medicare (Part A, Part B, or both); (5) the parents become divorced; or (6) the child stops being eligible for coverage under the Plan as a dependent child, as defined in this Brochure. See Section 10. *Eligibility*.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can result in a Qualifying event. If a proceeding in bankruptcy is filed with respect to your employer and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a Qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be Qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Reporting requirements

The Plan will offer COBRA continuation coverage to Qualified beneficiaries only after the Plan has been notified that a Qualifying event has occurred. Your Employer must notify the Plan of the occurrence of any of the following Qualifying events:

- Termination of your employment
- Reduction of your working hours resulting in a loss of coverage
- Your entitlement to Medicare (Part A, Part B, or both)
- Your death

This notification must be in writing and must be furnished within 30 days of the occurrence of the Qualifying event. Failure to provide such timely notification will subject the Employer to penalties under Federal law and can result in you and your dependents losing the right to elect COBRA coverage. Therefore, you and your dependents should also notify the Plan of these events in order to avoid losing your right to elect COBRA.

You, your spouse, or your dependent must notify the Plan of the occurrence of the following Qualifying events:

- **Your divorce**
- **Your child ceasing to be an eligible dependent**

This notification must be furnished in writing to the Plan within 60 days of the occurrence of the Qualifying event. Failure to furnish such notification within the required 60 days may result in the loss of the opportunity to elect continuation coverage.

All notices should be sent in writing to the NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146, Attention: Assistant Administrator. The notice must identify the Qualifying event, the date on which it occurred and the names of the individual(s) whose coverage will be lost. If the Qualifying event is a divorce, you must provide the Plan with a copy of the divorce decree.

IF YOU DO NOT PROVIDE TIMELY NOTIFICATION OF QUALIFYING EVENTS AS SET FORTH ABOVE, YOU AND YOUR ELIGIBLE DEPENDENTS WILL NOT BE PERMITTED TO ELECT COBRA CONTINUATION COVERAGE AND YOU WILL BE RESPONSIBLE FOR REIMBURSEMENT TO THE PLAN FOR ANY CLAIMS PAID ON YOU OR YOUR DEPENDENTS' BEHALF DURING THE PERIOD IN WHICH YOUR ELIGIBILITY FOR COVERAGE UNDER THIS PLAN SHOULD HAVE TERMINATED.

Once the Plan receives notice that a Qualifying event has occurred, COBRA continuation coverage will be offered to each of the Qualified beneficiaries. For each Qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will commence as of: (1) the date of the employee's death, when death of the employee is the reason for the Qualifying event, or (2) 31 days after the date of the Qualifying event, for all other Qualifying events.

Notice and election form

Within 14 days of receipt of notice that a Qualifying event has occurred, the Plan will send the affected person(s) a COBRA Notice and election form. This form will contain the details of the various coverage options available, their cost and the conditions under which the continuation coverage will terminate.

To elect COBRA coverage, you must return this form to the Plan within 60 days after the later of the date of the Qualifying event or the date of the Notice and election form. If the election form is not received within the 60-day period, you may not receive COBRA continuation coverage.

Each individual entitled to coverage as a Qualified beneficiary as the result of a Qualifying event has a right to make his or her own election of coverage. For example, your spouse and your dependent children have the right to choose continuation coverage for themselves if they lose coverage as a result of a Qualifying event, even if you do not. Employees may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

Addition of new dependents while enrolled in COBRA

If, while an Employee is enrolled in COBRA continuation coverage, a child is born to or placed for adoption with an Employee, the child may be enrolled for coverage for the balance of the period of your COBRA coverage period available to other Qualified beneficiaries with respect to the same Qualifying event. In order to add a new dependent, you must notify the Plan within 30 days after the birth or placement. You must provide the Plan with documentation supporting addition of the child. Adding a child may cause an increase in the amount you must pay for COBRA coverage if you are not already paying for family coverage. In the case of a birth, adoption, or placement for adoption for your new child, the Plan coverage for your child will be effective on the date of the birth, adoption, or placement for adoption.

Type of coverage

If continuation coverage is chosen, the Plan will make available health coverage which, as of the time that coverage is provided, is identical to the coverage provided under the Plan to similarly situated covered persons. If coverage for similarly situated covered persons is modified after continuation coverage has been elected, the continuation coverage will be modified accordingly.

Duration of continuation coverage

COBRA continuation coverage is a temporary continuation of coverage. The maximum duration of the continuation coverage is shown on the following chart:

Qualifying Event	Maximum Period for COBRA Coverage		
	Employee	Dependent Spouse	Dependent Children
Employee's termination of employment (for other than gross misconduct)	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for coverage)	18 months	18 months	18 months
Death of Employee	N/A	36 months	36 months
Employee becomes divorced	N/A	36 months	36 months
Employee becomes entitled to Medicare	N/A	36 months	36 months
Employee or Qualified Dependent is disabled at start of COBRA period or within first 60 days of COBRA coverage (see *Disability extension of 18-month period of continuation coverage*)	29 months	29 months	29 months
Dependent child ceases to be an Eligible Dependent	N/A	N/A	36 months

If the qualifying event is the death of the employee, the duration of the supplemental coverage described in Section 10. *Eligibility*, will be subtracted from the maximum period set forth above, such that surviving spouses of active Employees and surviving dependents of active and retired Employees will receive no more than 36 months of continued coverage.

If the maximum period of COBRA coverage is 18 months, there are two ways in which this 18-month period of COBRA continuation coverage can be extended, explained in this Section. However, the COBRA continuation coverage will under no circumstances ever exceed 36 months.

Disability extension of 18-month period of continuation coverage

If during the 18-month continuation period, you or anyone in your family covered by the Plan become disabled and receive a determination of disability from the Social Security Administration, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months, provided that you notify the Plan in a timely fashion. In order to be eligible for this extension, the disability must have started at some time before the 60th day of the commencement of COBRA continuation coverage and must last at least until the end of the initial 18-month period of continuation coverage. You must provide to the Plan with the determination letter from the Social Security Administration before the 18-month period of COBRA continuation coverage expires. The notice must be provided to: Assistant Administrator, NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146. This extension period will end at the earlier of the end of 29 months or when the disabled person becomes entitled to Medicare.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another Qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying event is properly given to the Plan. Example: If you terminate employment and elect COBRA coverage for you and your Qualified dependents, and you die within 18 months after your termination of employment, your dependents may extend their COBRA coverage for an additional 18 months, for a total of 36 months from the date your coverage ended as a result of your termination of employment. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Employee or former Employee dies, gets divorced or becomes entitled to Medicare. This extension is also available to a dependent child who stops being eligible under the Plan as a dependent child. This extension is only available if the second Qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying event not occurred.

When the Qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the Qualifying event, COBRA continuation coverage for Qualified beneficiaries other than the Employee, lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying event (36 months minus 8 months).

Premium payments

When you, your spouse, or your eligible dependents become eligible to receive COBRA continuation coverage, you will be advised of the premium charge for such coverage.

The COBRA premium charge is 102% of the cost of coverage. Any individual who receives COBRA coverage for an additional eleven (11) months due to a disability as determined by the Social Security Administration (as set forth above) must pay 150% of the cost of coverage during the 11-month disability extension period. The monthly premium is subject to change. You will be notified by the Plan if your premium amount changes.

Once continuation coverage is elected, premium payments must be made on time for the duration of the continuation period in order to keep the coverage in effect. You are required to pay the initial premium within 45 days of returning your Election form, and you must include retroactive payment for all months between your loss of coverage date and your payment. No claims incurred during this period will be processed or paid before the initial premium is received. Once the premium is received, claims incurred from the Qualifying event will be processed. All subsequent payments after the initial payment will be due on the first day of the month for that month's coverage. For example, premiums for the month of November must be paid on or before November 1.

There is a 30-day **grace period** for all payments after the initial payment (for example, the end of the grace period for payment for coverage in the month of May is May 31). If you have a claim during a month for which you have not paid your premium, the claim will not be paid until after

the Plan receives your payment for the month. If COBRA premium payments are not timely made, COBRA continuation coverage will terminate and will not be reinstated.

Please note that while the Plan send bills for COBRA coverage premium payments, it is your responsibility to make COBRA payments on time. You are required to pay your premiums regardless of whether you receive a bill from the Plan. If you do not make your payments on time, your coverage will end and cannot be reinstated.

Termination of continuation coverage

In addition to the expiration of the 18, 29, or 36-month periods, continuation coverage may be terminated for any of the following reasons:

- Timely premium payment has not been made
- You, your spouse, or dependents become covered under another health plan (as an employee or other insurer) and no pre-existing condition exclusion applies which affects the covered individual
- You, your spouse, or dependent obtained an extension of COBRA coverage based upon a disability determination from Social Security, but are no longer disabled. You must advise the Plan within 30 days of the determination that you are no longer disabled
- The Plan no longer provides group health coverage to any employees
- You, your spouse, or dependent first becomes, after electing COBRA coverage, entitled to Medicare (Part A, Part B, or both) (COBRA coverage will terminate for the Medicare-eligible person only)
- Your Employer withdraws from this Plan but continues to cover a classification of employees under another group health plan (in this case, you may be transferred to such other group health plan)
- Any other reason that would warrant termination of eligibility of an active participant (i.e., fraud)

ONCE COBRA COVERAGE IS TERMINATED, IT CANNOT BE REINSTATED.

Changes in persons covered

1. Once a Qualified beneficiary (i.e., former covered Employee or former covered dependent) is receiving COBRA continuation coverage, the Qualified beneficiary has the same right to enroll under that COBRA coverage dependents who lose other health insurance coverage or newly acquired dependents under the Plan's Special Enrollment rules (See Section 10. *Eligibility-Special Enrollment*) as if the Qualified beneficiary was an active employee under those rules. The Special Enrollment rules do not apply to a Qualified beneficiary who does not elect to receive COBRA coverage or a Qualified beneficiary whose COBRA continuation coverage period has expired. In addition, Qualified beneficiaries are entitled to request changes in their COBRA enrollment status during the annual Open Enrollment period. See Section 10. *Eligibility-Open Enrollment*. Dependents (other than children born to or adopted by former Employees during the Employee's COBRA period) who are added to a Qualified beneficiary's COBRA enrollment are not themselves considered Qualified beneficiaries.
2. If the addition of a new family member to a Qualified beneficiary's COBRA enrollment will result in a higher premium (as in an enrollment change from Self Only to Family coverage), the Plan will charge the additional premium for the coverage chosen.
3. A change in COBRA coverage from Family to Self Only enrollment may be made at any time by written request to the Plan.
4. Coverage of a dependent child under a COBRA Family enrollment terminates upon the child's attainment of age 26, whichever occurs first. On termination, the dependent may continue coverage under a new COBRA enrollment.
5. An enrollee should request a change from Family to Self Only when coverage of all family members under the Family enrollment has terminated.

If you have questions concerning COBRA

If you have questions about your COBRA continuation coverage, you should contact the Plan or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and telephone numbers of Regional and District EBSA Offices are available through EBSA's Web site at www.dol.gov/ebsa.

Keep us advised of address changes

In order to protect your family's rights, you should keep the Plan informed of any changes in the addresses of family members. You should also keep a copy of any notices you send to the Plan, for your records.

The following provisions describe other circumstances in which you may be allowed to continue coverage under this Plan

Continuation of coverage during leave under the Family Medical Leave Act

You may be entitled to have contributions made on your behalf under Family Medical Leave Act (FMLA). The FMLA entitles eligible Employees up to a maximum of 12 weeks of unpaid leave during any twelve-month period for specified family or medical purposes, such as the birth of a child, child care for the employee's children, the adoption of a child by the Employee, the need to care for a family member with a serious health condition, or the Employee's inability to perform the functions of his/her position because of a serious health condition. You may also be entitled up to a maximum of 12 weeks of unpaid leave because of a "qualifying exigency" (as defined in Department of Labor Regulations) arising out of the fact that your spouse, son, daughter or parent is in the Armed Forces serving in a foreign country on active duty or is called to service in a foreign country. (If you believe you are entitled to leave due to a "qualifying exigency", you should contact your Employer.)

In addition, the FMLA now permits a spouse, son, daughter, parent, or next of kin to take up to 26 weeks of leave (including any other FMLA leave in the same 12-month period) to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness incurred in the line of duty (or, under certain circumstances, prior injuries or illnesses that were aggravated by active military service). This leave may also apply for the care of a veteran of the Armed Forces if the veteran was not dishonorably discharged and the treatment necessitating the leave occurs within five years after the veteran leaves the Armed Forces.

You should check with your Employer to determine if the leave you wish to take is covered by the FMLA. Your Employer has an obligation to continue your medical coverage during a leave of absence under the provisions of the FMLA. Note: If you do not return to work after your FMLA leave ends, you may be required to repay the amount your Employer paid towards your coverage.

Military duty in the United States Armed Forces

If you are an active Employee and you enter the Armed Forces of the United States, you will be offered the opportunity to continue coverage under the Plan for yourself and your dependents pursuant to the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). Effective January 1, 2005, the maximum period of coverage under such election is the lesser of 24 months from the date your absence due to military service begins or the day after the date on which you fail to apply for or return to a position of employment. If the period of military service is less than 31 days, your coverage and your dependents' coverage will continue during the period of military service without charge. If the period of military service exceeds 31 days, you will be required to pay the applicable COBRA premium to continue coverage. If you do not elect to continue coverage during the period of military service, you will be entitled to have your coverage reinstated on the date you return to covered employment with a contributing Employer. No exclusion or waiting period will be imposed, except in the case of certain service-connected disabilities. These rights granted under USERRA are dependent upon uniformed service that ends honorably. In addition, your dependents may be eligible for health care coverage under the Federal program known as TRICARE. Contact the Plan for further details regarding your rights and obligations under USERRA.

Certificate of creditable coverage

If you are or expect to be covered by another group health plan, a Federal law known as HIPAA guarantees you certain rights under that plan. Under HIPAA, the period during which a group health plan may exclude or limit coverage for preexisting conditions is reduced or eliminated if the person had previous coverage under another group health plan. However, credit is not given for earlier coverage if you allowed that coverage to lapse, without replacement, for at least 63

days. If there will be some delay between your termination of coverage under this Plan and your enrollment in the new plan, a break in health coverage can be avoided by maintaining COBRA coverage in the meantime.

Under HIPAA, the Plan is required to provide, without charge, Certificates of Creditable Coverage to participants or dependents who are or were covered under the Plan upon the occurrence of certain events, or upon request. The purpose of these certificates is to provide evidence of the individuals' coverage to reduce a preexisting condition exclusion period under other plans, to help them enroll in other plans, or to obtain certain types of individual health coverage even if they have health problems.

A Certificate of Creditable Coverage will be issued to participants and dependents automatically upon cessation of coverage under the Plan. Additionally, a certificate will be provided at any time upon request, as provided in this Section.

Any individual who is covered under the Plan, or whose coverage has ceased within the previous 24 months, may request a certificate. Additionally, a certificate may be requested by a person or entity designated to make such a request on the individual's behalf; for instance, by a subsequent plan seeking to verify the individual's coverage. Certificates will be issued upon request regardless of whether the individual has previously received a certificate. Certificates will be provided in a reasonable and prompt fashion after the request is received.

All requests for Certificates of Creditable Coverage should be made in writing and should be directed to: Assistant Administrator, NALC Health Benefit Plan for Employees and Staff, P.O. Box 678, Ashburn, VA 20146.

Section 12. 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.

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.

Coinsurance

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

Congenital anomaly

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

Copayment

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

Cosmetic surgery

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

Cost-sharing

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

Covered services

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

Custodial care

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

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

pulse, and respirations; or administration and monitoring of feeding systems. The Plan determines whether services are custodial care.

Deductible

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

Effective date

The effective date of benefits described in this brochure is:

- January 1 for continuing enrollments;
- For new employees, the first day in pay and duty status.

Employee

The term "Employee" shall mean: (a) full-time permanent employees employed by an Employer; (b) former employees of an Employer on such terms and conditions as the Plan Administrator may decide; and (c) such other persons as the Plan Administrator may deem eligible, whether or not they are employed by an Employer, provided contributions are remitted on their behalf to the Plan pursuant to a written agreement.

Employer

The term "Employer" shall mean the NALC, the NALC HBP, the USLC MBA and such other organizations and entities as the Trustees and the Plan Administrator may deem eligible.

Experimental or investigational services

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

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

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

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

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 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 the Nongroup 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 for Employees and Staff.

You

You refers to the enrollee and each covered family member.

Section 13. ERISA rights

As a participant in the NALC Health Benefit Plan for Employees and Staff you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage risks.

- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under another group health plan, if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer; when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage from this Plan, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage under another plan.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to receive a written explanation for the denial, to obtain documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your

claim is frivolous. Note that you must exhaust the Plan's appeal process before filing any lawsuit. See Section 8. *Claim and appeal procedures.*

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 14. Discretion to Interpret the Plan

The Plan Administrator and the Board of Trustees may delegate any duties or powers as they deem necessary to carry out the administration of the Plan. The Plan Administrator and/or duly authorized designee(s) shall, subject to the requirements of law, determine the standard of proof required and have the exclusive right, power, and authority, in its sole and absolute discretion to administer, apply, and interpret the Plan, including this Brochure, the Trust Agreement and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the generality of the foregoing, the Plan Administrator and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for and the amount of benefits payable under the Plan;
- Formulate, interpret and apply rule, regulations, and policies necessary to administer the Plan in accordance with its terms;
- Decide questions, including legal and factual questions, relating to the payment of benefits under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan or other Plan documents; and
- Process and approve or deny benefit claims and rule on any benefit exclusions.

Index

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

Summary of benefits for the NALC Health Benefit Plan for Employees and Staff—2012

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 details, 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; Nothing routine screening services 15% of our allowance for other nonsurgical services Non-PPO: 30% of our allowance *	28
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	53
• Outpatient	PPO: 15% of our allowance * Non-PPO: 35% of our allowance *	55
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 *	59
• Medical emergency	PPO: 15% of our allowance * Non-PPO: 15% of our allowance *	59
Mental health and substance abuse treatment:	In-Network: Regular cost-sharing * Out-of-Network: Regular cost-sharing *	61
Prescription drugs:		
• Retail pharmacy	Preferred Network/Network: Generic: 20% of cost; Brand name: 30% of cost Preferred Network/Network Medicare: NALCSenior Antibiotic generic: Nothing Generic: 10% of cost; Brand name: 20% of cost Non-network: 45% of our allowance Non-network Medicare: 45% of our allowance	67

Benefits	You pay	Page
• Mail order	Non-Medicare: 60-day supply, $8 generic/$43 brand name 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 brand name Medicare: 60-day supply, $7 generic/$37 brand name Medicare: 90-day supply, $4 NALCSelect generic Medicare: 90-day supply, $4 NALCPreferred generic Medicare: 90-day supply, $10 generic/$55 brand name 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	67
Prescription medications for tobacco cessation:		
• Retail pharmacy	Preferred network/Network retail: Nothing Medicare Preferred network/Network retail: Nothing	68
• Mail order	Non-Medicare: 60-day supply, Nothing Non-Medicare: 90-day supply, Nothing Medicare: 60-day supply, Nothing Medicare: 90-day supply, Nothing	68
Dental care:	All charges except as listed in Section 5(g). under the *Accidental dental injury benefit*.	69
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 • Health Risk Assessment (HRA) • Healthy Rewards Program • Services for deaf and hearing impaired • Solutions for Caregivers (formerly called Enhanced Eldercare Services) • Weight Management Program • Worldwide coverage	70

Benefits	You pay	Page
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 CVS Caremark Specialty Pharmacy. Some costs do not count toward this protection.	24