NALC Health Benefit Plan

www.nalchbp.org

888-636-6252

National Association of Letter Carriers

2019

A Fee-for-Service Plan (High Option, Consumer Driven Health Plan, Value Option) with a Preferred Provider Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 4 for details. This Plan is accredited. See page 14.

IMPORTANT
- Rates: Back Cover
- Changes for 2019: Page 18
- Summary of benefits: Page 197

Sponsored and administered by the National Association of Letter Carriers (NALC), AFL-CIO
Who may enroll in this Plan:

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

To enroll, you must be or become a member of the National Association of Letter Carriers.
To become a member: If you are a Postal Service employee, you must be a dues-paying member of an NALC local branch. See page 166 and the back cover for more details. If you are a non-Postal employee, annuitant, survivor annuitant, or a Spouse Equity or TCC enrollee, you become an associate member of NALC when you enroll in the NALC Health Benefit Plan. See page 166 and the back cover for more details.

Membership dues: NALC dues vary by local branch for Postal employees. Associate members will be billed by the NALC for the $36 annual membership fee, except where exempt by law. Call Membership at 202-662-2856 for inquiries regarding membership, union dues, fees, or information on the NALC union. To enroll, you must be or become a member of the National Association of Letter Carriers.

Enrollment codes for this Plan
High Option: 321-Self Only; 323-Self Plus One; 322-Self and Family
CDHP: 324-Self Only; 326-Self Plus One; 325-Self and Family
Value Option: KM1-Self Only; KM3-Self Plus One; KM2-Self and Family

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from NALC Health Benefit Plan About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

- Visit www.medicare.gov for personalized help.
- Call 800-MEDICARE (800-633-4227), TTY: 877-486-2048.

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Introduction

This brochure describes the benefits of the NALC Health Benefit Plan under our contract (CS 1067) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. Customer Service may be reached at 888-636-NALC (6252) for High Option or through our website: www.nalchbp.org. The address and phone number for the NALC Health Benefit Plan High Option administrative office is:

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

The address and phone number for the NALC Consumer Driven Health Plan (CDHP) and Value Option is:

NALC CDHP or Value Option
P.O. Box 188050
Chattanooga, TN 37422-8050
855-511-1893

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2019, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2019, and changes are summarized on page 18. Rates are shown at the end of this brochure.

Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this Plan meets the minimum value standard for the benefits the Plan provides.

Plain Language

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

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your physician to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 703-729-4677 or 888-636-NALC (6252) and explain the situation.
  - If we do not resolve the issue:

CALL—THE HEALTH CARE FRAUD HOTLINE 877-499-7295 OR go to

www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include**,** falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (e.g., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The NALC Health Benefit Plan complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964 and Section 1557 of the ACA. Pursuant to Section 1557 the NALC Health Benefit Plan does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex. You may file a 1557 complaint with the HHS Office of Civil Rights, an FEHB Program carrier, or OPM. You may file a civil rights complaint with OPM by mail at:

Office of Personnel Management
Healthcare and Insurance
Federal Employee Insurance Operations
Attention: Assistant Director
1900 E Street NW Suite 3400-S
Washington, D.C. 20415-3610

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. 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. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. 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 take notes, ask questions, and understand answers.

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

- Bring the actual medications or give your doctor and pharmacist a list of all the medications and their dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as latex.
- 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 medication is what the doctor ordered. Ask the pharmacist about your medication if it looks different than you expected.
- Read the label and patient package insert when you get your medication, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

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

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?

- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic 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 or clinic.

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 or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission’s Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers. 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.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- 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.

Preventable Healthcare Aquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not 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, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called “Never Events” or “Serious Reportable Events.”

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 to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error.

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.

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and ACA's individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

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

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

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

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

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

  We don’t determine who is eligible for coverage and cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

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

  Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member. Self and Family coverage is for you and one eligible family member, or you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

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

Your employing or retirement office will not notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB Plan.

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

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

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

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

- **Children's Equity Act**

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2019 benefits of your old plan or option.** However, if your old plan left the FEHB at the end of the year, you are covered under that plan's **2018** benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

  If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the Spouse Equity Law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/.

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

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

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

  Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5 from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHB Program coverage.

- **Converting to individual coverage**

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

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

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

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

- **Health Insurance Marketplace** — If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

This Plan i**s a fee-for-service (FFS) pla**n. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. NALC Health Benefit Plan holds the following accreditation: Accreditation Association for Ambulatory Health Care (AAAHC) and vendors that support the NALC Health Benefit Plan hold accreditations from the National Committee for Quality Assurance and URAC. To learn more about this Plan's accreditations, please visit the following websites: www.aaahc.org, www.ncqa.org, and www.URAC.org. You can choose your own physicians, hospitals, and other health care providers.

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

General features of our High Option 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 877-220-NALC (6252) for the names of PPO providers or call us at 703-729-4677 or 888-636-NALC (6252) to request a PPO directory. We recommend that you call the PPO provider you select before each visit and verify they continue to participate in the Cigna HealthCare Shared Administration Open Access Plus (OAP) Network. You can also go to our Web page, which you can reach through the FEHB website, www.opm.gov/insure.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. However, we will process charges for radiology, laboratory, electrocardiogram (ECG/EKG), electroencephalogram (EEG), 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. In addition, we will pay medical emergencies specifically listed in Section 5(d). *Medical emergency* at the PPO benefit level. For members in the Commonwealth of Puerto Rico, all non-PPO physicians, hospitals, and facilities contracted through Zelis will be paid at the PPO benefit level.

How we pay providers

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

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

Some non-PPO providers or facilities may be contracted with our non-directed networks, Multiplan or Zelis (formerly Stratose). Non-PPO benefits will apply to charges received from these providers, but you may get a discount on their services. Please visit our website for more information.

General features of our Consumer Driven Health Plan (CDHP) and Value Option

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 855-511-1893 for the names of PPO providers. You can also go to our Web page, which you can reach through the FEHB website, www.opm.gov/insure. 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.

The Out-of-Network benefits are the standard benefits of this Plan. In-Network 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 Out-of-Network benefits apply. We will pay medical emergencies specifically listed in Section 5(d). Medical emergency at the In-Network 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.

Out-of-Network 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 Out-of-Network providers. When we obtain discounts through negotiation with Out-of-Network providers we share the savings with you.

Preventive benefits: This component provides first dollar coverage for specified preventive care for adults and children if you use an In-network provider.

Traditional benefits: After you have exhausted your Personal Care Account (PCA) and satisfied the calendar year deductible, the Plan starts paying benefits under the Traditional Health Coverage as described in Section 5.

Personal Care Account (PCA): You will have a Personal Care Account (Health Reimbursement Account) when you enroll in the CDHP or Value Option Health Plan. This component is used to provide first dollar coverage for covered medical services until the account balance is exhausted. The PCA does not earn interest and is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $6,650 for Self Only enrollment and $13,300 for a Self Plus One or Self and Family. Your specific plan limits may differ.

Your rights and responsibilities

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

High Option:

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

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

CDHP and Value Option

- We are a not-for-profit health plan sponsored by the National Association of Letter Carriers (NALC), AFL-CIO.
- This Plan is administered by Cigna HealthCare.

- Our preferred provider organization (PPO) is Cigna HealthCare OAP Network.
- Our prescription drug benefit manager is CVS Caremark®.

If you want more information about NALC CDHP or Value Option, call 855-511-1893, or write to NALC CDHP or Value Option, P.O. Box 188050, Chattanooga, TN, 37422-8050. You may also visit our website at www.nalchbp.org.

By law, you have the right to access your personal health information (PHI). For more information regarding access to PHI, visit our website at www.nalchbp.org. You can also contact us to request that we mail you a copy of that Notice.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities in this section or by visiting our website at www.nalchbp.org. You can also contact us to request that we mail you a copy of that Notice.

NALC Health Benefit Plan High Option, CDHP, and Value Option Member Rights and Responsibilities

Member Rights:

- You have the right to receive up-to-date information about your health plan, benefits available, the health care professionals, hospitals and other providers that participate in this Plan's PPO Network and your rights and responsibilities.
- You have the right to receive a copy of the Notice of the NALC Health Benefit Plan's Privacy Practices that outlines your rights and how to designate a personal representative which allows the Plan to discuss your protected health information.
- You have the right to privacy and confidentiality of your protected health information in accordance with applicable laws.
- You have the right to be treated with courtesy, dignity, and respect.
- You have the right to access quality care, regardless of race, color, national origin, sex, age, or disability.
- You have the right to participate fully with your network providers in decision making.
- You have the right to receive an explanation of benefits describing the benefits we pay, as well as to be informed of the reason for any adverse determination on a claim for benefits, including the specific utilization review criteria, guidelines or benefit provisions used in the determination.
- You have the right to appeal our decision in accordance with the Disputed Claims Process in Section 8 and to voice complaints.
- You have the right to request further information concerning anything you do not understand.
- You have the right to know that utilization management decisions are based only on the appropriateness of care and your current coverage. The NALC Health Benefit Plan does not reward network providers or others for denying coverage.
- You have the right to make suggestions and recommendations regarding the NALC Health Benefit Plan's Member Rights and Responsibilities statement.
- You have the right to receive a prompt reply when you ask us questions or request information.
- You have the right to know that neither you nor your health care provider can be punished for disputing a claim.
- You have the right to refuse to participate in research.

Member Responsibilities:

- Read the information the Plan provides you and ask us questions when you need to know more.
- Make sure you understand your benefits under the NALC Health Benefit Plan, including your costs for services as outlined in Section 4 of our brochure.
- Accept personal responsibility for any charges not covered by this Plan, if applicable.
- Provide information the Plan needs to process your claims (to the extent possible) including other health insurance coverage your family may have.

- Keep your provider informed about your medical history and your current health status including the medications you take so they can effectively treat you and manage your care.
- Inform your provider about any living will, medical power of attorney, or other directive that could affect your care.
- Participate with your provider to understand your health condition and develop mutually agreed upon treatment goals to the degree possible.
- Follow your provider's instructions and treatment plan, ask questions if you don't understand them.
- Treat your health care provider, their staff and others respectfully and honestly.
- Voice your opinions, concerns or complaints to our customer service and/or your health care provider.
- Make sure you obtain authorization required under the Plan for certain services.

Your medical and claims records are confidential

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

Section 2. Changes for 2019

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

Changes to this Plan

- We now require prior authorization for genetic testing. See pages 24, 34-35, 37, 44, 45, 108, 115-119, 168.
- We now cover gender reassignment surgery for the diagnosis gender dysphoria. See pages 24, 57-59, 62, 130-133, 135, 167.
- We now offer lower copayments and coinsurance for medication used to treat hypertension, diabetes, and asthma. See pages 85, 158.
- We now cover one preventive medicine counseling visit associated with a low dose cat scan (LDCT). See pages 38 and 109.
- We now cover preeclampsia screening for pregnant women. See pages 43 and 117.
- We now cover obesity screening for adolescents and children 6 years of age and older. See pages 41 and 112.
- We now cover screening for postpartum diabetes mellitus after pregnancy. See pages 38 and 109.
- We now cover screening for urinary incontinence under Well-woman care. See pages 38 and 109.
- We now cover the Shingrix vaccine for the prevention of herpes zoster or shingles. See pages 36 and 106.
- We have updated the medical requirements to qualify for statin prevention medication. See pages 87 and 160.
- We now cover skin cancer prevention counseling for children age 6 months through 21 years. See pages 42 and 113.
- We now offer the Transform Diabetes Care Program under *Wellness and Other Special Features*. See pages 90 and 163.
- We no longer apply manufacturer discounts on Specialty medications to the patient's deductible or out-of-pocket maximum. See pages 83, 86, 156 and 159.

Changes to our High Option only

- Your share of the non-Postal premium will increase for Self Only, increase for Self Plus One, or increase for Self and Family. See back cover.
- We no longer require prior authorization for the shingles vaccine. See page 36.
- We now cover speech generating devices, limited to $1,250 per year. See page 52.
- You now pay $20 for a spinal or extraspinal manipulation rendered by a PPO provider. Previously, you paid 15%. See page 54.

Changes to our Consumer Driven Health Plan only

- Your share of the non-Postal premium will increase for Self Only, increase for Self Plus One, or increase for Self and Family. See back cover.
- We now cover the initial office visit or consultation to assess a patient for acupuncture treatment. See page 128

Changes to our Value Option only

- Your share of the non-Postal premium will increase for Self Only, increase for Self Plus One, or increase for Self and Family. See back cover.
- We now cover the initial office visit or consultation to assess a patient for acupuncture treatment. See page 128.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at an NALC CareSelect retail pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

High Option:

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

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

Where you get covered care

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

- **Covered providers**

We provide benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act (PHSA). Coverage of practitioners is not determined by your state's designation as a medically underserved area (MUA).

Covered professional providers are medical practitioners who perform covered services when acting within the scope of their license or certification under applicable state law and who furnish, bill, or are paid for their health care services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

- **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), Health Facilities Accreditation Program (HFAP), 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:** 1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission; or 2) any other institution licensed as a hospital, operating under the supervision of a staff of physicians with 24 hours a day registered nursing service, and is primarily engaged in providing general inpatient acute care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities. All these services 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 Use Disorder—In-Network Benefits*).
- **Residential Treatment Center:** Residential treatment centers (RTCs) are accredited by a nationally recognized organization and licensed by the state, district, or territory to provide residential treatment for medical conditions, mental health conditions, and/or substance use. Accredited health care facilities (excluding hospitals, skilled nursing facilities, group homes, halfway houses, schools, and similar types of facilities) provide 24-hour residential evaluation, treatment and comprehensive specialized services relating to the individual's medical, physical, mental health, and/or substance use therapy needs. RTCs offer programs for persons who need short-term transitional services designed to achieve predicted outcomes focused on fostering improvement or stability in functional, physical and/or mental health, recognizing the individuality, strengths, and needs of the persons served. Benefits are available for services performed and billed by RTCs, as described on pages 80 and 153. If you have questions about treatment at an RTC, please contact Optum at 877-468-1016 (High Option) or 855-511-1893 for the CDHP/Value Option.
- **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 use disorder.

What you must do to get covered care

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

- **Transitional care**

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

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

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

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 703-729-4677 or 888-636-NALC (6252) for High Option. For Consumer Driven Health Plan or Value Option call 855-511-1893. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

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

- **Inpatient hospital admission**

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

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital whether or not they have contacted us.

Note: To determine if your inpatient surgical procedure requires prior authorization, see *Other services* in this section.

- **Warning**

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

- **How to precertify an admission**

- **High Option:** You, your representative, your physician, or your hospital must call us at 877-220-NALC (6252) prior to admission, unless your admission is related to a mental health and substance use disorder. In that case, call 877-468-1016.
- **Consumer Driven Health Plan and Value Option**: You, your representative, your physician, or your hospital must call us at 855-511-1893 prior to 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.
- 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 days requested for hospital stay.
- 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, your physician or the hospital must contact us within two business days for precertification of additional days for your baby.

Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

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

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

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

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

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

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

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

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

- **Exceptions**

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States with the exception of surgeries which require prior approval in this section.
- You have another group health insurance policy that is the primary payor for the hospital stay with the exception of surgeries which require prior approval in this section.

- 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, including surgeries which require prior approval in this section.

- **Precertification of radiology/imaging services**

  The following outpatient radiology/imaging services need to be precertified:
  - CT/CAT – Computerized Axial Tomography;
  - MRI – Magnetic Resonance Imaging;
  - MRA – Magnetic Resonance Angiography;
  - NC – Nuclear Cardiac Imaging Studies; and
  - PET – Positron Emission Tomography.

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

  For outpatient CT/CAT, MRI, MRA, NC, or PET scans, your provider, or facility must call 877-220-NALC (6252) for High Option or 855-511-1893 for Consumer Driven Health Plan/Value Option before scheduling the procedure.

- **Exceptions**

  You do not need precertification in these cases:
  - You have another health insurance that is the primary payor including Medicare Part A
  - The procedure is performed outside the United States;
  - You are admitted to a hospital; or
  - The procedure is performed as an emergency.

- **Warning**

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

Precertification, prior authorization, or prior approval for other services

- **Other services**

  High Option: Other non-routine services require precertification, preauthorization, or prior approval.
  - All specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs. Call CVS Specialty™ at 800-237-2767 for prior approval. See Section 5(a). *Treatment therapies* and Section 5(f). *Prescription Drug Benefits.*
  - Anti-narcolepsy, ADD/ADHD, certain analgesics and certain opioid medications require prior authorization. Call CVS Caremark® at 800-933-NALC (6252) to obtain a list of medications or to obtain prior authorization. See Section 5(f). *Prescription Drug Benefits.*
  - All compound drugs. Call CVS Caremark® at 800-933-NALC (6252) for prior approval. See Section 5(f). *Prescription Drug Benefits.*
  - Spinal surgeries performed in an inpatient or outpatient setting. Call Cigna at 877-220-NALC (6252) to obtain prior approval. See Section 5(b). *Surgical procedures.*
  - Organ/tissue transplants and donor expenses. Call Cigna at 800-668-9682 for prior approval. See Section 5(b). *Organ/tissue transplants.*
  - Mental health and substance use disorder care. Call OptumHealth Behavorial Solutions at 877-468-1016 for prior approval. See Section 5(e). *Mental Health and Substance Use Disorder Benefits.*
  - Applied Behavioral Analysis (ABA) therapy. Call Optum at 877-468-1016 for prior approval. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals.*

- Durable medical equipment (DME). Call us at 888-636-NALC (6252) for prior approval. See Section 5(a). *Durable medical equipment*.
- All inpatient surgeries related to bariatric procedures, experimental and investigational procedures, or cosmetic procedures will be reviewed for medical necessity at the time of the inpatient hospital precertification review.
- Genetic testing. Call 833-801-9264 for prior approval. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals*.
- Gender reassignment surgery. Call Cigna at 877-220-NALC (6252) for prior approval. See Section 5(b). *Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals*.

Consumer Driven Health Plan and Value Option: These non-routine services require precertification, preauthorization, prior approval, or pre-notification:

- All specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs. Call CVS Specialty™ at 800-237-2767. See Section 5 (a). *Treatment therapies* and Section 5(f). *Prescription Drug Benefits*.
- Anti-narcolepsy, ADD/ADHD, certain analgesics and certain opioid medications require prior authorization. Call CVS Caremark® at 800-933-NALC (6252) to obtain a list of medications or to obtain prior authorization. See Section 5(f). *Prescription Drug Benefits*.
- All compound drugs. Call CVS Caremark® at 800-933-NALC (6252) for prior approval. See Section 5(f). *Prescription Drug Benefits*.
- Spinal surgeries performed in an inpatient or outpatient setting. See Section 5 (b). *Surgical procedures*. Call Cigna at 855-511-1893 or write to P.O. Box 188050, Chattanooga, TN 37422-8050.
- Organ/tissue transplants and donor expenses. See Section 5(b). *Organ/tissue transplants*. Call Cigna at 855-511-1893 or write to P.O. Box 188050, Chattanooga, TN 37422-8050.
- Mental health and substance use disorder care. Call Cigna Behavioral Health at 855-511-1893 for prior approval. See Section 5(e). *Mental Health and Substance Use Disorder Benefits*.
- Applied Behavioral Analysis (ABA) therapy. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals*. Call Cigna at 855-511-1893 for prior approval, or write to P.O. Box 188050, Chattanooga, TN 37422-8050.
- Durable medical equipment (DME). See Section 5(a). *Durable medical equipment*. Call Cigna at 855-511-1893 or write to P.O. Box 188050, Chattanooga, TN 37422-8050.
- All inpatient surgeries related to bariatric procedures, experimental and investigational procedures, or cosmetic procedures will be reviewed for medical necessity at the time of the inpatient hospital precertification review.
- Genetic testing. Call 833-801-9264 for prior approval. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals*.
- Gender reassignment surgery. Call Cigna at 855-511-1893 for prior approval. See Section 5(b). *Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals*.

- **Exceptions**

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

- **Non-urgent care claims**

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

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

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

- **Urgent care claims**

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

  If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

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

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

- **Concurrent care claims**

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

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

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

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

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

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

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

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your Costs for Covered Services

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

Cost-sharing

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

Copayments

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

High Option example: When you see your PPO physician, you pay a $20 copayment per office visit, and when you are admitted to a non-PPO hospital, you pay $350 per admission.

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

Deductible

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

High Option:

The calendar year deductible is $300 per person and $600 per family. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $300. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $600. Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $600.

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.

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

Consumer Driven Health Plan and Value Option:

Your deductible is your bridge between your Personal Care Account (PCA) and your Traditional Health Coverage. After you have exhausted your PCA, you must pay your deductible before your Traditional Health Coverage begins.

	The calendar year deductible is $2,000 per person and $4,000 per family for In-Network providers. The calendar year deductible is $4,000 per person and $8,000 per family for Out-of-Network providers. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered In-Network expenses applied to the calendar year deductible for your enrollment reach $2,000 ($4,000 for covered Out-of-Network expenses). Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered In-Network expenses applied to the calendar year deductible for your enrollment reach $4,000 ($8,000 for covered Out-of-Network expenses). Under a Self and Family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered In-Network expenses applied to the calendar year deductible for family members reach $4,000 ($8,000 for covered Out-of-Network expenses). Note: Your deductible in subsequent years may be reduced by rolling over any unused portion of your Personal Care Account remaining at the end of the calendar year(s). There is no separate deductible for mental health and substance use disorder benefits under the CDHP or Value Option.
Coinsurance	**High Option:** Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: When you see a non-PPO physician, your coinsurance is 30% of our allowance for office visits. **Consumer Driven Health Plan and Value Option:** Coinsurance is the percentage of our allowance that you must pay for your care after you have exhausted your Personal Care Account (PCA) and met your calendar year deductible. Example: When you see an Out-of-Network physician for an office visit, your coinsurance is 50% of our Plan allowance and the difference, if any, between our allowance and the billed amount.
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 or not you are responsible for the total charge depends on the contracts that Cigna HealthCare and OptumHealth Behavioral Solutions have 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 888-636-NALC (6252).
Differences between our allowance and the bill	**High Option:** Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For more information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10. Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

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

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

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

Consumer Driven Health Plan and Value Option: In-Network providers agree to accept our Plan allowance. If you use an In-Network provider, you never have to worry about paying the difference between the Plan allowance and the billed amount for covered services. If you have exhausted your Personal Care Account (PCA), you will be responsible for paying your deductible and also the coinsurance under the Traditional Health Coverage.

Out-of-Network providers – if you use an Out-of-network provider, you will have to pay the difference between the Plan allowance and the billed amount. You may use your Personal Care Account for this amount.

Note: In-Network providers reduce your out-of-pocket amount.

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

High Option: For those services subject to a deductible, coinsurance and copayment (including mental health and substance use disorder care), we pay 100% of the Plan allowance for the remainder of the calendar year after your cost-share totals:

- $3,500 per person and $5,000 per 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 CareSelect Network pharmacy and mail order copayment amounts (see Section 5(f). *Prescription Drug Benefits*) count toward a $3,100 per person or $4,000 family annual 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.

Consumer Driven Health Plan and Value Option:

If you have exceeded your Personal Care Account and satisfied your deductible, the following should apply:

When you use In-Network providers, network retail pharmacies, or our mail order pharmacy, your out-of-pocket maximum is $6,600 per person or $13,200 per family. When you use Out-of-Network providers, your out-of-pocket maximum is $12,000 per person and $24,000 per family.

Under a Self Only enrollment, the out-of-pocket maximum is considered satisfied when your covered In-Network (including preferred network retail and mail order pharmacy) deductible, copayments and coinsurances applied to the out-of-pocket maximum for your enrollment reach $6,600 ($12,000 for covered Out-of-Network expenses). Under a Self Plus One enrollment, the out-of-pocket maximum is considered satisfied when your covered In-Network (including preferred network retail and mail order pharmacy) copayments and coinsurances applied to the out-of-pocket maximum for your enrollment reach $13,200 ($24,000 for covered Out-of-Network expenses). Under a Self and Family enrollment, the out-of-pocket maximum is considered satisfied when your covered In-Network (including preferred network retail and mail order pharmacy) copayments and coinsurances applied to the out-of-pocket maximum for your enrollment reach $13,200 ($24,000 for covered Out-of-Network expenses).

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

- Any amount in excess of our Plan allowance or maximum benefit limitations or expenses not covered under the Traditional Health Coverage
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 21 - 23)
- The 50% coinsurance for prescriptions purchased at a non-network pharmacy or for additional fills at an NALC CareSelect pharmacy
- 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"
- Any associated costs when you purchase medications in excess of the Plan's dispensing limitations

Carryover	If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
If we overpay you	We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High Option Benefits

(See page 18 for how our benefits changed this year and page 197 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 Self Plus One enrollment or $600 per Self and Family enrollment). 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, laboratory, electrocardiogram (ECG/EKG), electroencephalogram (EEG), the administration of anesthesia and the emergency room visit billed by non-PPO providers at the PPO benefit level, based on Plan allowance, if the services are rendered at a PPO hospital or PPO ambulatory surgical center.
- Be sure to read Section 4. *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR CERTAIN OUTPATIENT RADIOLOGY/ IMAGING PROCEDURES.** FAILURE TO DO SO MAY RESULT IN A DENIAL OF BENEFITS. Please refer to precertification information in Section 3 to be sure which procedures require precertification.
- **YOU MUST GET PRIOR AUTHORIZATION FOR APPLIED BEHAVIORAL ANALYSIS (ABA) THERAPY.** FAILURE TO DO SO WILL RESULT IN A DENIAL OF BENEFITS. Please refer to prior authorization information in Section 3.
- **YOU MUST GET PRIOR APPROVAL FOR GENETIC TESTING**. FAILURE TO DO SO WILL RESULT IN A DENIAL OF BENEFITS. Please refer to prior authorization information in Section 3.

Benefit Description	You pay After calendar year deductible. . .
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians (including specialists) or urgent care centers • Office or outpatient visits • Office or outpatient consultations • Second surgical opinions	PPO: $20 copayment per visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Professional services of physicians • Hospital care • Skilled nursing facility care • Inpatient medical consultations • Home visits	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Benefit Description	You pay After calendar year deductible. . .
Diagnostic and treatment services (cont.)	
Note: For initial examination of a newborn child covered under a family enrollment, see *Preventive care, children* in this section. Note: For routine post-operative surgical care, see Section 5(b). *Surgical procedures.*	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Routine eye and hearing examinations (except as listed in* Preventive care, children *and* Hearing services*... in this section)* • *Nonsurgical treatment for weight reduction or obesity (except as listed in* Educational classes and programs *in this section)*	*All charges*
Lab, x-ray and other diagnostic tests	
Tests and their interpretation, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Non-routine sonograms • Electrocardiogram (EKG) • Electroencephalogram (EEG) • Bone density study • CT Scans/MRI/MRA/NC/PET (Outpatient requires precertification - See Section 3) • Genetic testing Note: Benefits are available for diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's medical condition. Genetic testing requires prior authorization. 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 877-220-NALC (6252), or visit our website at www.nalchbp.org.	Nothing (No deductible)
Not covered: Routine tests, except listed under Preventive care, adult *in this section.*	*All charges*

Benefit Description	You pay After calendar year deductible. . .
Preventive care, adult	
Routine examinations, limited to: • Routine physical exam—one annually, age 22 or older • Initial office visit associated with a covered routine sigmoidoscopy or colonoscopy screening test For a complete list of adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule please visit our website at www.nalchbp.org. Note: When the NALC Health Benefit Plan is the primary payor for medical expenses, the Herpes Zoster (shingles) vaccine, 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.nalchbp.org or call CVS Caremark® Customer Service at 800-933-NALC (6252) to locate a local participating pharmacy. Screenings, limited to: • Abdominal aortic aneurysm screening by ultrasonography—one in a lifetime, for men age 65 through 75 with smoking history • Alcohol and drug use disorder screening—age 22 and older • Basic or comprehensive metabolic panel blood test—one annually • Biometric screening- one annually; including: - calculation of body mass index (BMI) - waist circumference measurement - total blood cholesterol - blood pressure check - fasting blood sugar • Chest x-ray—one annually • Colorectal cancer screening for adults age 50 through 75, including: - Fecal occult blood test—one annually - Fecal immunochemical test (FIT) – one annually - Computed tomographic (CT) colonography – one every 5 years - Double contrast barium enema (DCBE) – one every 5 years	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.)	
- Stool-based DNA such as ColoGuard – one every 3 years - Sigmoidoscopy screening—one every 5 years - Colonoscopy screening (with or without polyp removal)—one every 10 years • Complete Blood Count (CBC)—one annually • Depression screening—age 18 and older • Diabetes screening—as recommended by the U.S. Preventive Services Task Force (USPSTF) • Electrocardiogram (ECG/EKG)—one annually • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglycerides)—one every five years, age 20 and older • General health panel blood test—one annually • Hepatitis B virus infection screening—for adults at high risk for infection as recommended by the U.S. Preventive Services Task Force (USPSTF) • Hepatitis C virus infection screening: - One—for adults born between 1945 and 1965 - For adults at high risk for infection as recommended by the U.S. Preventive Services Task Force (USPSTF) • High blood pressure screening—as recommended by the U.S. Preventive Services Task Force (USPSTF) • Human Immunodeficiency Virus (HIV)—adults age 65 and younger • Lung Cancer screening with low-dose Computerized Tomography (LDCT) Scan—one annually for adults age 55 through 80 who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. • 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) • Tuberculosis screening for adults at increased risk, age 18 and older • Urinalysis—one annually • Well-woman care based on current recommendations such as: - 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)	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.)	
- Cervical cancer screening (Pap smear) age 21 to age 65—one annually - Cervical cancer screening (Pap smear) over age 65—one every 2 years - Chlamydial infection test - Contraception counseling with reproductive capability as prescribed - Counseling for sexually transmitted infections - Counseling and screening for human immunodeficiency virus for sexually active women - Gonorrhea screening limited to: • Women age 24 and younger • Women age 25 and older at increased risk as recommended by the U.S. Preventive Services Task Force (USPSTF) - Human papillomavirus (HPV) testing age 30 through age 65—one every three years - Osteoporosis screening limited to: • Women age 40 - 64 at increased risk as recommended by the U.S. Preventive Services Task Force (USPSTF) • Women age 65 and older - Postpartum diabetes mellitus screening for women with a history of gestational diabetes mellitus - Routine mammogram—age 35 and older, as follows: • Age 35 through 39—one during this five year period • Age 40 and older—one every calendar year - Screening and counseling for interpersonal and domestic violence - Screening for urinary incontinence Note: Additional well-women preventive care services may be listed separately in this section. Note: Breast tomosynthesis (3-D mammogram) is considered a preventive care screening test as long as it is performed in conjunction with a routine screening mammography. Note: We cover a preventive medicine counseling associated with a low-dose Computerized Tomography (LDCT) scan—one annually.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You pay After calendar year deductible. . .
Preventive care, adult (cont.)	
Note: 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 use • Aspirin use for the prevention of cardiovascular disease • Breast cancer chemoprevention • Depression • Fall prevention—age 65 and older • Obesity (includes dietary counseling for adults at higher risk for chronic disease) • Sexually transmitted infections • Skin cancer prevention for adults age 24 and younger • 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. Note: See Section 5(f). *Prescription Drug Benefits* for a listing of preventive medications available to promote better health as recommended under the ACA. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services, will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/ HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women/ For additional information: www.healthfinder.gov/myhealthfinder/default.aspx	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Routine lab tests, except listed under Preventive care, adult in this section.*	*All charges*

Preventive care, adult - continued on next page

Benefit Description	You pay After calendar year deductible. . .
Preventive care, adult (cont.)	
• *Immunizations, boosters, and medications for travel or work-related exposure.* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.*	*All charges*
Preventive care, children	
Well-child visits, examinations, and immunizations as described in the Bright Futures Guidelines provided by the American Academy of Pediatrics • Examinations, limited to: - Initial examination of a newborn child covered under a family enrollment - Well-child care—routine examinations through age 2 - Routine physical exam (including camp, school, and sports physicals)—one annually, age 3 through 21 - Examinations done on the day of covered immunizations, age 3 through 21 • For a complete list of childhood immunizations covered through age 21, please see the American Academy of Pediatrics Bright Futures Guidelines at brightfutures.aap.org/Pages/default.aspx or visit our website at www.nalchbp.org. Note: When the NALC Health Benefit Plan is the primary payor for medical expenses, the seasonal flu vaccine and pediatric pneumococcal vaccine will be paid in full when administered by a pharmacy that participates in the NALC Flu and Pneumococcal Vaccine Administration Network. A full list of participating pharmacies is available at www.nalchbp.org or call CVS Caremark® Customer Service at 800-933-NALC (6252) to locate a local participating pharmacy. Screenings, limited to: • Alcohol and drug use assessment as recommended by Bright Futures/AAP—age 11 through 21 • Chlamydial infection test • Depression screening as recommended by the U.S. Preventive Services Task Force (USPSTF)—age 12 through 17 • Developmental screening (including screening for autism spectrum disorder) as recommended by Bright Futures/AAP – through age 3	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Preventive care, children - continued on next page

Benefit Description	You pay After calendar year deductible. . .
Preventive care, children (cont.)	
• Developmental surveillance and behavioral assessment as recommended by Bright Futures/AAP—age 21 and younger • Fasting lipoprotein profile (total cholesterol, LDL, HDL and triglycerides): - One, age 9 through 11 - One, age 18 through 21 - Age 17 and younger with medical indications as recommended by Bright Futures/AAP • Gonorrhea screening—as recommended by the U.S. Preventive Services Task Force (USPSTF) • Hearing screening: - Age 3 through 10 - For those at high risk as recommended by Bright Futures/AAP, through age 21 • Hemoglobin/hematocrit - one, at ages: 12 months, 15 months and 30 months - one annually, for females age 11 through 21 • Hepatitis B virus infection screening—for adolescents at high risk for infection as recommended by the U.S. Preventive Services Task Force (USPSTF) • High blood pressure screening—as recommended by the U.S. Preventive Services Task Force (USPSTF) • Human Immunodeficiency Virus (HIV) - Age 15 and older - Age 14 and younger at increased risk as recommended by the U.S. Preventive Services Task Force (USPSTF) • Lead screening test—age 6 and younger with medical indications as recommended by Bright Futures/AAP • Newborn metabolic screening panel—one, age 2 months and younger • Newborn screening hearing test—one in a lifetime • Newborn screening test for congenital hypothyroidism, phenylketonuria (PKU) and sickle cell—one in a lifetime • Obesity screening in children and adolescents age 6 through 21 • Oral health assessment - one, ages 12 months and 18 months - one, annually through age 6 • Annual routine pap test for females age 21 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, children - continued on next page

Benefit Description	You pay After calendar year deductible. . .
Preventive care, children (cont.)	
• Sexually transmitted infections screening as recommended by Bright Futures/AAP – children age 11 and older • Syphilis screening for children age 11 and older as recommended by the U.S. Preventive Services Task Force (USPSTF) • Tuberculosis screening—for those at high risk as recommended by Bright Futures/AAP, through age 21 • Urinalysis—one annually, age 5 through 21 • Vision screening for amblyopia or its risk factors (limited to: strabismus, astigmatism, anisometropia, and hyperopia) as recommended by the U.S. Preventive Services Task Force (USPSTF) and Bright Futures/AAP—one annually age 3 through 5 • Vision screening as recommended by Bright Futures/AAP, age 6 through 18 Note: For the coverage of the initial newborn exam see *Diagnostic and treatment services* in this section. Preventive medicine counseling by a covered primary care provider as recommended by the U.S. Preventive Services Task Force (USPSTF), limited to: • Alcohol and drug use screening—age 18 through 21 • Anemia • Application of fluoride varnish to primary teeth by a covered primary care provider—age 5 and younger • Dental cavities • Major depressive disorder • Obesity • Sexually transmitted infections • Skin cancer prevention • Tobacco use Note: See Section 5(f). *Prescription Drug Benefits* for a listing of preventive medications available to promote better health as recommended under the ACA. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services, will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org.	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.)	
HHS: www.healthcare.gov/prevention CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women/ For additional information: www.healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx Note: See Section 5(a). *Educational classes and programs* for more information on educational classes and nutritional therapy for self management of diabetes, hyperlipidemia, hypertension and obesity.	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 • Routine sonograms • Fetal monitoring • Tetanus-diphtheria, pertussis (Tdap)-one dose during each pregnancy • Breastfeeding support and counseling • Rental of breastfeeding equipment Screening tests as recommended by the USPSTF for pregnant women, limited to: • Depression screening • Gestational diabetes for pregnant women • Hepatitis B • Human Immunodeficiency Virus (HIV) • Iron deficiency anemia • Preeclampsia screening	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.)	
• 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: • Lactation support and counseling for breastfeeding • Tobacco use counseling	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Other tests medically indicated for the unborn child or as part of the maternity care Note: Here are some things to keep in mind: • Genetic tests performed as part of a routine pregnancy require prior authorization. • You do not need to precertify your vaginal or cesarean 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 vaginal 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 Plus One or 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. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). • Non-routine sonograms are payable under diagnostic testing. 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

Maternity care - continued on next page

Benefit Description	You pay After calendar year deductible. . .
Maternity care (cont.)	
Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity 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
Family Planning	
Voluntary family planning services, limited to: • Voluntary female sterilization • Surgical placement of implanted contraceptives • Insertion of intrauterine devices (IUDs) • Administration of an injectable contraceptive drug (such as Depo provera) • Removal of a birth control device • Management of side effects of birth control • Services related to follow up of services listed above • Office visit associated with a covered family planning service Note: Outpatient facility related to voluntary female sterilization is payable under outpatient hospital benefit. See Section 5(c). *Outpatient hospital.* For anesthesia related to voluntary female sterilization, see Section 5 (b). *Anesthesia.* Note: We cover oral contraceptives, injectable contraceptive drugs (such as Depo provera), diaphragms, intrauterine devices and implanted contraceptives, (such as Implanon) only under the Prescription drug benefit. See Section 5(f). *Prescription Drug Benefits.*	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Vasectomy (see Section 5(b). *Surgical procedures*)	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling except as listed in this section.*	*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 $2,500 calendar year maximum per person to diagnose or treat infertility.	PPO: 15% of the Plan allowance and all charges after we pay $2,500 in a calendar year Non-PPO: 30% of the Plan allowance and all charges after we pay $2,500 in a calendar year
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures such as:* - *Artificial insemination (AI)* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygot intrafallopian transfer (ZIFT)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* • *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 sublinual allergy desensitization* • *Environmental control units, such as air conditioners, purifiers, humidifiers, and dehumidifiers*	*All charges*
Treatment therapies	
• Intravenous (IV)/Infusion Therapy—Home IV and antibiotic therapy • Respiratory and inhalation therapies • Growth hormone therapy (GHT) • Cardiac rehabilitation therapy - Phases I and II only	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

Treatment therapies - continued on next page

Benefit Description	You pay After calendar year deductible. . .
Treatment therapies (cont.)	
Note: Phase I begins in the hospital after a major heart event and includes visits by the cardiac rehab team, education, and nutritional counseling, along with rehab. Phase II begins after leaving the hospital and is a comprehensive program consisting of medical evaluation, prescribed exercise, behavior modification, heart monitoring, education, and counseling, typically performed in an outpatient setting. Phases III and IV are supervised safe exercise (performed in the home or gym) and are not covered by the Plan. Note: Specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs, available through CVS Specialty™ 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 CVS 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
• Applied Behavioral Analysis (ABA) therapy for autism spectrum disorder rendered by a PPO provider: - Age 3 through 11 up to 15 hours per week - Age 12 through 18 up to 9 hours per week Note: Prior authorization is required for ABA therapy. Call 877-468-1016 to find a covered provider and to obtain prior authorization.	PPO: 15% of the Plan allowance Non-PPO: All charges
Not covered: • *Chelation therapy, except as treatment for acute arsenic, gold, lead, or mercury poisoning* • *Prolotherapy* • *School-based ABA therapy* • *ABA therapy covered by Medicaid under the Individuals with Disabilities Education Act (IDEA)* • *ABA therapy not prior authorized*	*All charges*

Benefit Description	You pay After calendar year deductible. . .
Physical, occupational, and speech therapies	
• A combined total of 75 rehabilitative and habilitative visits per calendar year for treatment provided by a licensed registered therapist or physician for the following: - Physical therapy - Occupational therapy - Speech therapy Therapy is covered when the attending physician: • Orders the care; • Identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • Indicates the length of time the services are needed. Note: 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.
• Physical therapy to prevent falls for community-dwelling adults age 65 and older as recommended by the U.S. Preventive Services Task Force (USPSTF) Therapy is covered when the attending physician: • Orders the care; • Identifies the specific professional skills the patient requires; and • Indicates the length of time the services are needed.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and difference, if any, between our allowance and the billed amount
Not covered: • *Exercise programs* • *Maintenance rehabilitative therapy that maintains a functional status or prevents decline in function*	*All charges*

Benefit Description	You pay After calendar year deductible. . .
Hearing services (testing, treatment, and supplies)	
• For treatment (excluding hearing aids) related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • First hearing aid and examination, limited to services necessitated by accidental injury	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Hearing aid and related examination for neurosensory hearing loss limited to a maximum Plan payment of $500 per ear with replacements covered every 3 years.	PPO: Nothing up to the Plan limit and all charges after we pay $500 per ear (No deductible) Non-PPO: Nothing up to the Plan limit and all charges after we pay $500 per ear (No deductible)
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*
Vision services (testing, treatment, and supplies)	
• Office visit for eye examinations for covered diagnoses, such as cataract, diabetic retinopathy and glaucoma	PPO: $20 copayment per visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) when purchased within one year • Tests and their interpretations for covered diagnoses, such as: - Fundus photography - Visual field - Corneal pachymetry Note: We only cover the standard intraocular lens prosthesis, such as for cataract surgery. Note: For childhood preventive vision screenings see *Preventive care, children* in this section. Note: See Section 5(h). *Wellness and Other Special Features, 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

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

Benefit Description	You pay After calendar year deductible. . .
Vision services (testing, treatment, and supplies) (cont.)	
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*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Prosthetic sleeve or sock • 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	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

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After calendar year deductible. . .
Orthopedic and prosthetic devices (cont.)	
• 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
• Wigs for hair loss due to the treatment of cancer (with a maximum Plan payment of $200 per lifetime).	PPO: 15% of the Plan allowance and all charges after we pay $200 per lifetime (No deductible) Non-PPO: 30% of the Plan allowance and all charges after we pay $200 per lifetime (No deductible)
• One pair of custom functional foot orthotics, including casting, every 5 years when prescribed by a physician (with a maximum Plan payment of $400)	PPO: 15% of the Plan allowance and all charges after we pay $400 Non-PPO: 30% of the Plan allowance and all charges after we pay $400
• Repair of existing custom functional foot orthotics (with a maximum Plan payment of $100 every 3 years)	PPO: 15% of the Plan allowance and all charges after we pay $100 Non-PPO: 30% of the Plan allowance and all charges after we pay $100
Not covered: • *Wigs (cranial prosthetics) except as listed in this section* • *Orthopedic and corrective shoes* • *Arch supports, heel pads and heel cups* • *Foot orthotics (shoe inserts) except as listed under* Orthopedic and prosthetic devices *in this section* • *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 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
• Speech generating devices, limited to $1,250 per calendar year	PPO: 15% of the Plan allowance and all charges after we pay $1,250 in a calendar year Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after we pay $1,250 in a calendar year

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, shower chairs, commode chairs, shower commode chairs, and similar household equipment* • *Safety, convenience, and exercise equipment, such as treadmills, exercise bicycles (including functional electrical stimulation equipment), stair climbers, and free weights* • *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 that do not meet the criteria 1 thru 6 on page 52*	*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*

Benefit Description	You pay After calendar year deductible. . .
Chiropractic	
Limited to: • One set of spinal x-rays annually	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Limited to: • 24 spinal or extraspinal manipulations per calendar year Note: When spinal and extraspinal manipulations are performed on the same day, each manipulation applies to the calendar year maximum.	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
Limited to: • Initial office visit or consultation • 24 office visits per calendar year when rendered on the same day as a covered spinal or extraspinal manipulation	PPO: $20 copayment per visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Any treatment not specifically listed as covered	*All charges*
Alternative treatments	
Limited to: • Initial office visit or consultation to assess patient for acupuncture treatment	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
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.	PPO: $20 copayment per visit (No deductible) 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	Nothing for services obtained through the tobacco cessation program offered by the Plan (No deductible)

Educational classes and programs - continued on next page

Benefit Description	You pay After calendar year deductible. . .
Educational classes and programs (cont.)	
- 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 866-QUIT-4-LIFE (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 diabetes, obesity, and overweight individuals with risk factors for cardiovascular disease (such as: abnormal fasting glucose levels, hyperlipidemia, hypertension, and metabolic syndrome) 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). *Wellness and Other Special Features*.	PPO: Nothing (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
The Weight Talk Program® through Optum™ is a personal coaching program designed to achieve measurable, sustainable weight loss. It is delivered through regular phone-based coaching sessions with a dedicated coach. Participants set realistic weight goals and through small multiple behavior changes learn how to achieve and maintain a healthy weight for the rest of their lives. Participants receive scheduled telephone coaching sessions with a dedicated coach or registered dietitian. Participants also have lifetime access to weight loss tools, educational resources and community support on the Weight Talk® website. Each participant receives a Welcome Kit containing a weight loss workbook, food journal, tape measure and a wireless activity monitor that tracks and uploads steps, calories burned, distance traveled, and activity duration wirelessly to the Weight Talk® website. This allows participants to track their activity history on the website and allows coaches to see the participants' progress throughout the course of the program.	Nothing for services obtained through the Weight Talk Program® offered by the Plan (No deductible)

Educational classes and programs - continued on next page

Benefit Description	You pay After calendar year deductible. . .
Educational classes and programs (cont.)	
Individuals can enroll in the Weight Talk Program® online at www.nalchbp.org or call the toll-free number at 844-305-0758. A personal dedicated coach is available Sunday through Friday 7:00 a.m. through 3:00 a.m. and Saturday 9:00 a.m. through 12:00 a.m. Eastern Time.	Nothing for services obtained through the Weight Talk Program® offered by the Plan (No deductible)
Not covered: • *Over-the-counter medications or dietary supplements prescribed for weight loss* • *Prescription medications prescribed for weight loss*	*All charges*

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 Self Plus One enrollment or $600 per Self and Family enrollment).
- 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, laboratory, electrocardiogram (ECG/EKG), electroencephalogram (EEG), the administration of anesthesia and the emergency room visit billed by non-PPO providers at the PPO benefit level, based on Plan allowance, if the services are rendered at a PPO hospital or PPO ambulatory surgical center.
- Be sure to read Section 4. *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The services 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.*
- **YOU MUST GET PRIOR APPROVAL FOR SPINAL SURGERIES PERFORMED IN AN INPATIENT OR OUTPATIENT SETTING. Call 877-220-6252 to obtain prior approval.**
- **YOU MUST GET PRIOR APPROVAL FOR GENDER REASSIGNMENT SURGERY. FAILURE TO DO SO WILL RESULT IN A DENIAL OF BENEFITS. See Section 3. *How You Get Care.***
- **Not all surgical procedures require prior approval.** You may contact the Plan at 888-636-NALC (6252) to determine coverage for the surgical procedure prior to the service being rendered.

Benefit Description	You pay
Note: The calendar year deductible applies ONLY when we say, "(calendar year deductible applies)."	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies	PPO: 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.)	
• Insertion of internal prosthetic devices. See Section 5(a). *Orthopedic and prosthetic devices*, for device coverage information. • Vasectomy • Debridement of burns • 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 at least one clinically significant obesity-related co-morbidity including but not limited to type 2 diabetes, cardiovascular disease, hypertension, obstructive sleep apnea, hyperlipidemia, or debilitating arthritis. 2. Diagnosis of morbid obesity for a period of one year prior to surgery. 3. The patient has participated in a supervised weight-loss program, of at least six months duration, that includes dietary therapy, physical activity and behavior modification. Evidence in the medical record that attempts at weight loss in the one year period prior to surgery have been ineffective. 4. The patient is age 18 or older. 5. Medical and psychological evaluations have been completed and the patient has been recommended for bariatric surgery. 6. A repeat or revised bariatric surgical procedure is covered only when determined to be medically necessary or a complication has occurred. • Gender reassignment surgical benefits are limited to the following: - For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, and placement of an erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, and labiaplasty Note: Prior approval is required for gender reassignment surgery. For more information about prior approval, please refer to Section 3. *How You Get 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 (calendar year deductible applies)

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
Note: Your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan. Note: Benefits for gender reassignment surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender reassignment surgery for any condition other than gender dysphoria. • Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The patient must meet all requirements.** - Prior approval is obtained - Patient must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted - Diagnosis of gender dysphoria by a qualified healthcare professional • Patient's gender dysphoria is not a symptom of another mental disorder • Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning - Patient must meet the following criteria: • Documentation the individual has lived for at least 12 continuous months in a gender role that is congruent with their gender identity (including place of employment, family, social and community activities) • 12 months of continuous hormone therapy appropriate to the patient's gender identity • Two referral letters from mental health professionals (Master's level or more advanced degree from an accredited institution) to include a letter of recommendation for the procedure • If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled - Reversal of a gender reassignment surgery is covered only when determined to be medically necessary or a complication occurs.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
Note: 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). Note: Simple repair of a laceration (stitches) and immobilization by casting, splinting, or strapping of a sprain, strain, or fracture, will be considered under this benefit when services are rendered after 72 hours of the accident. Note: We only cover the standard intraocular lens prosthesis for cataract surgery. Note: **Initial** inpatient (non-elective) surgery rendered by a non-PPO surgeon for the surgical treatment of appendicitis, brain aneurysms, burns, or gunshot wounds will be paid at the PPO benefit level.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
• Voluntary female sterilization • Surgical placement of implanted contraceptives • Insertion of intrauterine devices (IUDs) • Removal of birth control device Note: We cover intrauterine devices and implanted contraceptives, (such as Implanon) only under the Prescription Drug Benefit. See Section 5(f). *Prescription Drug Benefits.*	PPO: Nothing Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
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*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
• *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 • *Weight loss surgery for implantable devices such as Maestro Rechargeable System*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance; and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a congenital anomaly (condition that existed at or from birth and is a significant deviation from the common form or norm). Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedemas 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.*	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.)	
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* • *Surgery related to sexual dysfunction (except gender reassignment surgeries specifically listed as covered)*	*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	
Cigna ***Life***SOURCE Transplant Network®—The Plan participates in the Cigna ***Life***SOURCE Transplant Network®. Before your initial evaluation as a potential candidate for a transplant procedure, you or your physician must contact Cigna HealthCare at 800-668-9682 and speak to a referral specialist in the Comprehensive Transplant Case Management Unit. You will be given information about this program including a list of participating providers. Charges for services performed by a Cigna ***Life***SOURCE Transplant Network® provider, whether incurred by the recipient or donor are paid at 85% including inpatient hospital, surgical and any other medical expenses. Participants in the program must obtain prior approval from the Plan to receive limited travel and lodging benefits.	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®
Limited Benefits—If you do not obtain prior approval or do not use a designated facility, or if we are not the primary payor, we pay a maximum of $100,000 for each listed transplant (kidney limit, $50,000), for these combined expenses: pre-transplant evaluation; organ procurement; and inpatient hospital, surgical and medical expenses. We pay benefits according to the appropriate benefit section, such as Section 5(c). *Inpatient hospital*, and *Surgical procedures* in this section. The limitation applies to expenses incurred by either the recipient or donor. Note: Some transplants listed may not be covered through the Cigna ***Life***SOURCE Transplant Network®. Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
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: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
• Kidney • Kidney/pancreas • Liver • Lung single/bilateral/lobar • Pancreas	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. See *Other services* in Section 3 for prior authorization procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. 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 - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteoporosis	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, 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 - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Blood or marrow stem cell transplants covered only in a National Cancer Institute (NCI) or National Institutes of Health (NIH) approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols limited to: • Autologous transplants for: - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/ lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Breast cancer	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Childhood rhabdomyosarcoma - Epithelial ovarian cancer - Mantle Cell (non-Hodgkin's lymphoma) Note: If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®
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 - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - 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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Amyloidosis - Neuroblastoma Note: If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
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. Note: When a CRNA is medically directed by an anesthesiologist, then the applicable Plan allowance will be split 50/50 between the CRNA and the anesthesiologist.	PPO: Nothing when services are related to the delivery of a newborn. 15% of the Plan allowance for anesthesia services for all other conditions. Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Professional services provided in: • Hospital outpatient department • Ambulatory surgical center • Office • Other outpatient facility Note: If surgical services are rendered at a PPO hospital or ambulatory surgical center, we will pay up to the Plan allowance for services of non-PPO anesthesiologists at the PPO benefit level. Note: When a CRNA is medically directed by an anesthesiologist, then the applicable Plan allowance will be split 50/50 between the CRNA and the anesthesiologist.	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)

Anesthesia - continued on next page

Benefit Description	You pay
Anesthesia (cont.)	
Professional services provided for: • Voluntary female sterilization Note: When a CRNA is medically directed by an anesthesiologist, then the applicable Plan allowance will be split 50/50 between the CRNA and the anesthesiologist.	PPO: Nothing Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and (b), the calendar year deductible applies to only a few benefits. In that case, we say "(calendar year deductible applies)." The calendar year deductible is $300 per person ($600 per Self Plus One enrollment or $600 per Self and Family enrollment).
- 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, laboratory, electrocardiogram (ECG/EKG), electroencephalogram (EEG), the administration of anesthesia and the emergency room visit billed by non-PPO providers at the PPO benefit level, based on Plan allowance, if the services are rendered at a PPO hospital or PPO ambulatory surgical center.
- Be sure to read Section 4. *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- Charges billed by a facility for implantable devices, surgical hardware, etc., are subject to the Plan allowance which is based on the provider's cost plus a reasonable handling fee. The manufacturer's invoice that includes a description and cost of the implantable device or hardware may be required in order to determine benefits payable.
- The amounts listed below are for charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. See Sections 5(a) or (b) for costs associated with the professional charge (i.e., physicians, etc.).
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
Inpatient hospital	
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • Birthing room • General nursing care • Meals and special diets Note: We cover a private room only when you must be isolated to prevent contagion. Otherwise, we pay the hospital's average charge for semiprivate accommodations. If the hospital has private rooms only, we base our payment on the average semiprivate rate of the most comparable hospital in the area. Note: When the non-PPO hospital bills a flat rate, we will exclude all charges and request an itemized bill.	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 and the difference, if any, between our allowance and the billed amount 15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
Note: When room and board charges are billed by a hospital, inpatient benefits apply. For **Observation** room charges 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 and the difference, if any, between our allowance and the billed amount 15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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 and the difference, if any, between our allowance and the billed amount 15% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
Take-home items: • Medical supplies, appliances, and equipment; and any covered items billed by a hospital for use at home	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and the difference, if any, between our allowance and the billed amount (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 medications • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Physical, occupational, and speech therapy (when surgery performed on the same day) Note: When surgery is not performed on the same day, see Section 5(a). *Physical, occupational, and speech therapies* for coverage of these therapies.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center (cont.)	
Note: For accidental injuries, see Section 5(d). *Emergency Services/Accidents*. For accidental dental injuries, see Section 5(g). *Dental Benefits*. Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental physical impairment or as the result of an accidental dental injury as defined in Section 5(g). *Dental Benefits*. We do not cover the dental procedures or the anesthesia service when billed by the anesthesiologist. Note: Specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs dispensed in an outpatient hospital are subject to the Specialty Drug copayment. See *Outpatient hospital or ambulatory surgical center,* in this section.	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 35% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
• Outpatient observation room and all related services	PPO: $200 copayment Non-PPO: 35% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
• Outpatient services and supplies for the delivery of a newborn • Outpatient services and supplies for a voluntary female sterilization	PPO: Nothing Non-PPO: 35% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Plan pays for pre-operative testing within 7 days of surgery. Screening tests, limited to: • Chest x-rays • Electrocardiograms • Urinalysis • Blood work Note: To reduce your out-of-pocket costs for laboratory services use LabCorp or Quest Diagnostics, see Section 5(a). *Lab, x-ray and other diagnostic tests.* Note: Diagnostic tests, such as magnetic resonance imaging, throat cultures, or similar studies are not considered as preadmission testing.	PPO: 15% of the Plan allowance Non-PPO: 35% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay
Outpatient hospital or ambulatory surgical center (cont.)	
• Specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs Note: Prior approval is required for all specialty drugs used to treat chronic medical conditions. Call CVS Specialty™ at 800-237-2767 to obtain prior approval, more information, or a complete list.	PPO: • 30-day supply: $150 • 60-day supply: $250 • 90-day supply: $350 Non-PPO: • 30-day supply: $150 and the difference, if any, between our Plan allowance and the charged amount • 60-day supply: $250 and the difference, if any, between our Plan allowance and the charged amount • 90-day supply: $350 and the difference, if any, between our Plan allowance and the charged amount
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 up to 30 days annually for a combination of inpatient and outpatient hospice services.	PPO: 15% of the Plan allowance, and all charges after 30 day annual limit (calendar year deductible applies) Non-PPO: 30% of the Plan allowance, and all charges after 30 day annual limit (calendar year deductible applies)
Not covered: • *Private nursing care* • *Homemaker services*	*All charges*

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	
• *Bereavement services*	*All charges*
Ambulance	
• Professional ambulance service to an outpatient hospital or ambulatory surgical center Note: When air ambulance transportation is provided by a non-PPO provider, we will pay up to the Plan allowance at the PPO benefit level. Note: When ambulance transportation to the nearest PPO facility 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. Note: When ambulance transportation to the nearest PPO facility 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 Self Plus One enrollment or $600 per Self and Family enrollment). 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, laboratory, electrocardiogram (ECG/EKG), electroencephalogram (EEG), the administration of anesthesia and the emergency room visit billed by non-PPO providers at the PPO benefit level, based on Plan allowance, if the services are rendered at a PPO hospital or PPO ambulatory surgical center.
- Be sure to read Section 4. *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

What is an accidental injury?

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

What is a medical emergency condition?

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

What are medical emergency services?

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

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	
If you receive the care within 72 hours after your accidental injury, we cover: • Related nonsurgical treatment, including office or outpatient services and supplies • Related surgical treatment, limited to: - Simple repair of a laceration (stitching of a superficial wound) - Immobilization by casting, splinting, or strapping of a sprain, strain, or fracture • Local professional ambulance service to an outpatient hospital when medically necessary Note: For surgeries related to your accidental injury not listed above, see Section 5(b). *Surgical procedures*. Note: We pay inpatient professional and hospital benefits when you are admitted. See Section 5(a). *Diagnostic and treatment services,* Section 5(b). *Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals*, and Section 5(c). *Services Provided by a Hospital or Other Facility, and Ambulance Services*. Note: For dental benefits for accidental injury, see Section 5(g). *Dental Benefits*.	PPO: Nothing (No deductible) Non-PPO: Nothing and the difference, if any, between the Plan allowance and the billed amount (No deductible)
Services received after 72 hours	Medical and outpatient hospital benefits apply. See Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals*, Section 5(b). *Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals* and Section 5(c). *Outpatient hospital or ambulatory surgical center* for the benefits we provide.
Medical emergency	
Outpatient hospital medical emergency service for a medical emergency condition	PPO: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance and the difference, if any, between our allowance and the billed amount Note: When you need outpatient medical emergency services for a medical emergency and cannot access a PPO hospital, we will pay the non-PPO hospital charges, up to the Plan allowance, at the PPO benefit level.
Professional services of physicians and urgent care centers: • Office or outpatient visits • Office or outpatient consultations	PPO: $20 copayment per visit (No deductible) Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Medical emergency - continued on next page

Benefit Description	You pay After the calendar year deductible…
Medical emergency (cont.)	
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
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. Note: When ambulance transportation to the nearest PPO facility 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 Use Disorder Benefits

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

When you receive care, you must get our approval for services. If you do, cost-sharing and limitations for mental health and substance use disorder 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 Self Plus One enrollment or $600 per Self and Family enrollment). The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" to show when the calendar year deductible does not apply.
- The Out-of-Network benefits are the standard benefits of this Plan. In-Network benefits apply only when you use an In-Network provider. When no In-Network provider is available, Out-of-Network benefits apply.
- Be sure to read Section 4. *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PREAUTHORIZATION FOR THE FOLLOWING OUTPATIENT SERVICES:** Intensive outpatient program treatment, outpatient electro-convulsive treatment, psychological testing, methadone maintenance, and outpatient treatment visits beyond 45-50 minutes in duration with or without medication management. Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the preauthorization process. See the instructions after the benefits descriptions below.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

Benefit Description	You pay After the calendar year deductible. . .
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
In-Network and Out-of-Network benefits	
• Outpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Outpatient medication management • Outpatient telemental or virtual visits rendered by providers such as psychiatrists, psychologists, or clinical social workers Note: To find a telemental/virtual visit provider call Optum at 877-468-1016.	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

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

Benefit Description	You pay After the calendar year deductible. . .
In-Network and Out-of-Network benefits (cont.)	
Note: Applied Behavioral Analysis (ABA) therapy benefit is listed in Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.* Note: For assistance in finding In-Network services and treatment options, such as Medication-Assisted Therapy (MAT) for Substance Use Disorder (SUD), call 855-780-5955.	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 • 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. Note: When ambulance transportation to the nearest In-Network facility is provided by a Out-of-Network provider, we will pay up to the Plan allowance at the In-Network benefit level.	In-Network: 15% of the Plan allowance Out-of-Network: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount
If LabCorp or Quest Diagnostics performs your covered lab services, you will have no out-of-pocket expense and you will not have to file a claim. Ask your doctor to use LabCorp or Quest Diagnostics for lab processing. To find a location near you, call 877-220-NALC (6252), or visit our website at www.nalchbp.org.	Nothing (No deductible)
• Professional ambulance service to the nearest inpatient hospital equipped to handle your condition Note: When air ambulance transportation is provided by an Out-of-Network provider, we will pay up to the Plan allowance at the In-Network benefit level. Note: When ambulance transportation to the nearest In-Network facility is provided by a 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)
• Outpatient observation room and all related services	In-Network: $200 copayment (No deductible) Out-of-Network: 35% of the Plan allowance and the difference, if any, between our allowance and the billed amount

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

Benefit Description	You pay After the calendar year deductible. . .
In-Network and Out-of-Network benefits (cont.)	
• 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)
Residential Treatment Center (RTC) - Precertification prior to admission is required. A preliminary treatment plan and discharge plan must be developed and agreed to by the member, provider (residential treatment center (RTC)), and case manager prior to admission. We cover inpatient care provided and billed by an RTC for members enrolled and participating in an approved plan of care, and when the care is medically necessary for treatment of a medical, mental health, and/or substance use disorder: • Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility. Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house, schools, or similar type facility. Note: Benefits are not available for non-covered services, including: respite care; outdoor residential programs; wilderness treatment or services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services; custodial or long term care and domiciliary care provided because care in the home is not available or is unsuitable.	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 intellectual disabilities* • *Treatment for marital discord*	*All charges*

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

Benefit Description	You pay After the calendar year deductible. . .
In-Network and Out-of-Network benefits (cont.)	
• *Services rendered or billed by schools, residential treatment centers, or half-way houses, and/or members of their staff 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: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.* *Note: Exclusions that apply to other benefits apply to these mental health and substance use disorder benefits, unless the services are included in a treatment plan that we approve.*	*All charges*

Preauthorization

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

For services that require prior authorization, you must follow all of the following network authorization processes:

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

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

- When Medicare is your primary payor, call the Plan at 703-729-4677 or 888-636-NALC (6252) to preauthorize treatment if:
  - Medicare does not cover your services; or
  - Medicare hospital benefits are exhausted and you do not want to use your Medicare lifetime reserve days.

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

Where to file claims

Claims should be submitted to:

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

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

Section 5(f). Prescription Drug Benefits

Important things to keep in mind about these benefits:

- We cover prescribed medications and supplies as described in the chart beginning on page 85.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- 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 888-636-NALC (6252) for authorization.
- When we say "Medicare" in the *You pay* section we mean you have Medicare Part B or Part D and it is primary.
- Be sure to read Section 4. *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse Practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a 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.
  - **Network pharmacy**—Present your Plan identification card at an NALC CareSelect Network pharmacy to purchase prescription drugs. Call 800-933-NALC (6252) to locate the nearest network pharmacy.
  - **Non-network pharmacy—**You may purchase prescriptions at pharmacies that are not part of our network. You pay full cost and must file a claim for reimbursement. See *When you have to file a claim* in this section.
  - **Mail order—**Complete the patient profile/order form. Send it along with your prescription(s) and payment, in the preaddressed envelope to:

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

- **We use a formulary.** A formulary is a list of prescription drugs, both generic and brand name, that provide a safe, effective and affordable alternative to non-formulary drugs, which have a higher cost-share. Our formulary is open and voluntary. It is called the NALC Health Benefit Plan Drug List. If your physician believes a brand name drug is necessary, or if there is no generic available, ask your physician to prescribe a formulary brand name drug from our NALC Health Benefit Plan Formulary Drug List. You will pay the appropriate retail coinsurance and mail order copayment amounts for generic and formulary brand name drugs on this list. Your out-of-pocket costs will be higher for non-formulary brand name drugs not on the NALC Health Benefit Plan Formulary Drug List. To order this list, call 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 800-933-NALC (6252).

- **These are the dispensing limitations.**
  - For prescriptions purchased at 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 Specialty™.
  - 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.

Most prescriptions can be filled after 75% of the drug has been used. However, individual pharmacists may refuse to fill or refill a prescription if there is a question about the order's accuracy, validity, authenticity, or safety to the patient, based on the pharmacists professional judgement. 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 generally include, but may not be limited to, drugs and biologics (medications created from living cells cultured in a laboratory) that may be complex to manufacture, can have routes of administration more challenging to administer (injectable, infused, inhaled, topical, and oral), may have special handling requirements, may require special patient monitoring, and may have special programs mandated by the FDA to control and monitor their use. These drugs are typically used to treat chronic, serious, or life-threatening conditions. Examples of such conditions include, but are not limited to, myelogenous leukemia (AML), cancer, Crohn's disease, cystic fibrosis, growth hormone disorder, hemophilia, hepatitis C, HIV, immune deficiencies, multiple sclerosis, osteoarthritis, psoriasis, and rheumatoid arthritis. Specialty drugs are often priced much higher than traditional drugs.

- All specialty drugs require preauthorization and may include step therapy; call CVS Specialty™ at 800-237-2767. Our benefit includes the Advanced Control Specialty Formulary that includes a step therapy program and uses evidence-based protocols that require the use of a preferred drug(s) before non-preferred specialty drugs are covered. The Advanced Control Specialty Formulary is designed as a specialty drug formulary that includes generics and clinically effective brands as determined through clinical evidence. The therapy classes chosen for Advanced Control Specialty Formulary have multiple specialty drugs available that are considered therapeutically equivalent (similar safety and efficacy), thus providing the opportunity to utilize the lowest cost drug(s). In addition, categories, therapies and tiering changes could be updated every quarter and added to the formulary. Please refer to the Advance Control Specialty formulary drug list for more information about the drugs and classes.
- All specialty drugs must be purchased through CVS Specialty™.
- Some specialty medications may qualify for third party copayment assistance programs which could lower your out-of-pocket costs for those medications. When specialty medication is purchased with a third party copayment assistance coupon, rebate, or card, the Plan will not apply the amount of the discount towards your out-of-pocket maximum.
- The Specialty Connect feature allows you to submit your specialty medication prescription to your local CVS Pharmacy. See Section 5(h). *Wellness and Other Special Features* or call 800-237-2767 for more information.

Note: Decisions about prior approval are based on evidence-based guidelines developed by CVS Caremark® Pharmacy's clinical team and include, but are not limited to, FDA approved indications and/or independent expert panels.

We require prior authorization (PA) for certain drugs to ensure safety, clinical appropriateness and cost effectiveness. PA criteria is designed to determine coverage and help to promote safe and appropriate use of medications. Medications for anti-narcolepsy, ADD/ADHD, certain analgesics and certain opioids will require PA. To obtain a list of drugs that require PA, please visit our website, www.nalchbp.org or call 888-636-NALC (6252).

- **All anti-narcolepsy, ADD/ADHD, certain analgesics and certain opioid medications require prior authorization. Call CVS Caremark® at 800-933-NALC (6252) to obtain prior authorization.**

A compound drug is a medication made by combining, mixing, or altering ingredients in response to a prescription, to create a customized drug that is not otherwise commercially available. Certain compounding chemicals (over-the-counter (OTC) products, bulk powders, bulk chemicals, and proprietary bases) are not covered through the prescription benefit will be determined through preauthorization. Refill limits may apply.

- **All compound drugs require prior authorization. Call CVS Caremark® at 800-933-NALC (6252) to obtain authorization.**
- **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 800-933-NALC (6252) to request a copy.
- **When you have Medicare Part D.** We waive the following at retail when Medicare Part D is primary payor and covers the drug:
  - Refill limitations
  - Day supply

Note: See Section 9. *Coordinating Benefits with Medicare and Other Coverage,* for more information on Medicare Part D.

- **When you have to file a claim.** If you purchase prescriptions at a non-network pharmacy, foreign/overseas pharmacy, or elect to purchase additional 30-day refills at a network pharmacy, complete the short-term prescription claim form. Mail it with your prescription receipts to the NALC Prescription Drug Program. Receipts must include the patient's name, prescription number, medication 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 and made a payment, we will pay as secondary up to our Plan limit. If no payment is made by the primary payor, complete the short-term prescription claim form, attach the drug receipts and other carrier's reason for denial 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 an NALC CareSelect Network retail pharmacy, or need additional claim forms, call 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 medications (including those administered during a non-covered admission or in a non-covered facility) that by federal law of the United States require a physician's prescription for their purchase, except as shown in *Not covered* • Insulin • Needles and syringes for the administration of covered medications • Drugs for sexual dysfunction, when the dysfunction is caused by medically documented organic disease • Vitamins and minerals that by federal law of the United States require a physician's prescription for their purchase Note: You may purchase up to a 90-day supply (84-day minimum) of covered drugs and supplies at a CVS Caremark® Pharmacy through our Maintenance Choice Program. You will pay the applicable mail order copayment for each prescription purchased. Note: We will waive the one 30-day fill and one refill limitation at retail for patients confined to a nursing home, patients who are in the process of having their medication regulated, or when state law prohibits the medication from being dispensed in a quantity greater than 30 days. Call the Plan at 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: • Network retail: - Generic: 20% of cost (10% of cost for hypertension, diabetes, and asthma) - Formulary brand: 30% of cost - Non-formulary brand: 45% of cost • Non-network retail: 45% of the Plan allowance, and the difference, if any, between our allowance and the billed amount Retail Medicare: • Network retail Medicare: - NALCSenior Antibiotic generic: Nothing - Generic: 10% of cost (5% of cost for hypertension, diabetes, and asthma) - Formulary brand: 20% of cost - Non-formulary brand: 30% of cost • Non-network retail Medicare: 45% of the Plan allowance, and the difference, if any, between our allowance and the billed amount Mail order: • 60-day supply: $8 generic/$43 Formulary brand/$58 Non-formulary brand • 90-day supply: $5 NALCSelect generic • 90-day supply: $7.99 NALCPreferred generic • 90-day supply: $12 generic/$65 Formulary brand/$80 Non-formulary brand (for hypertension, diabetes, and asthma: $8 generic/$50 Formulary brand/$70 Non-formulary brand) Mail order Medicare: • 60-day supply: $4 generic/$37 Formulary brand/$52 Non-formulary brand • 90-day supply: $4 NALCSelect generic • 90-day supply: $4 NALCPreferred generic • 90-day supply: $6 generic/$55 Formulary brand/$70 Non-formulary brand (for hypertension, diabetes, and asthma: $4 generic/$40 Formulary brand/$60 Non-formulary brand) Note: If there is no generic equivalent available, you pay the brand name copayment. Note: If the cost of a prescription is less than the mail order copayment amount, you will pay the cost of the prescription.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	
	Note: Non-network retail includes additional fills of a maintenance medication at a Network pharmacy without prior Plan authorization. This does not include prescriptions purchased at a CVS Caremark® Pharmacy through our Maintenance Choice Program.
Specialty drugs – including biotech, biological, biopharmaceutical, and oral chemotherapy drugs. All specialty drugs require prior approval. Call CVS Specialty™ at 800-237-2767 to obtain prior approval, more information, or a complete list. You may also obtain a list of specialty drugs by visiting www.nalchbp.org. Note: Some specialty medications may qualify for third party copayment assistance programs which could lower your out-of-pocket costs for those medications. When specialty medication is purchased with a third party copayment assistance coupon, rebate, or card, the Plan will not apply the amount of the discount towards your out-of-pocket maximum.	Non-Medicare/Medicare: • CVS Specialty™ Mail Order: - 30-day supply: $150 - 60-day supply: $250 - 90-day supply: $350 Note: Refer to dispensing limitations in this section.
• Medical foods and nutritional supplements when administered by catheter or nasogastric tubes Note: If medical foods or nutritional supplements are dispensed by a pharmacy, you will pay the appropriate pharmacy copay/coinsurance.	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)
Preventive care medications	
Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, when prescribed by a health care professional and filled at a network pharmacy. • Over-the-counter vitamin D supplements (600-800 IU per day) for adults age 65 and older (prescription required) • Over-the-counter low-dose aspirin (75 and 81 mg) for the prevention of colorectal cancer and cardiovascular disease for adults age 50-59 as recommended by the USPSTF (prescription required) • Over-the-counter low-dose aspirin for pregnant women at high risk for preeclampsia (prescription required) • Over-the-counter vitamin supplements containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid for women planning a pregnancy or capable of becoming pregnant (prescription required)	Retail: Network retail—Nothing

Preventive care medications - continued on next page

Benefit Description	You pay
Preventive care medications (cont.)	
• Prescription oral fluoride supplements for children from age 6 months through 5 years	Retail: Network retail—Nothing
• FDA-approved prescription medications for tobacco cessation • Over-the-counter medications for tobacco cessation (prescription required) • FDA-approved prescription contraceptive drugs for women, including injectable drugs such as Depo provera • Diaphragms • Intrauterine devices • Medications, limited to Tamoxifen or Raloxifene for risk reduction of primary breast cancer for women who are at increased risk for breast cancer as recommended by the USPSTF • Statin preventive medications for adults at increased risk of cardiovascular disease (CVD), age 40 through 75, with a calculated 10-year CVD event risk of 10% or greater, as recommended by the USPSTF Note: The "morning after pill" is considered preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy. Note: Call us at 703-729-4677 or 888-636-NALC (6252) prior to purchasing this medication at a Network retail or mail order pharmacy.	Retail: Network retail—Nothing Retail Medicare: Network retail—Nothing Mail order: • 60-day supply: Nothing • 90-day supply: Nothing Mail order Medicare: • 60-day supply: Nothing • 90-day supply: Nothing
Not covered: • *Drugs and supplies when prescribed for cosmetic purposes* • *Nutrients and food supplements, even when a physician prescribes or administers them, except as listed in this section* • *Over-the-counter medications, vitamins, minerals, and supplies, except as listed above* • *Over-the-counter tobacco cessation medications purchased without a prescription* • *Tobacco cessation medications purchased at a non-network retail pharmacy* • *Prescription oral fluoride supplements purchased at a non-network retail pharmacy* • *Prescription contraceptives for women purchased at a non-network retail pharmacy* • *Over-the-counter contraceptives purchased without a prescription*	*All charges*

Preventive care medications - continued on next page

Benefit Description	You pay
Preventive care medications (cont.)	
• *Prescription drugs for infertility* • *Over-the-counter medications or dietary supplements prescribed for weight loss* • *Prescription medications prescribed for weight loss* • *Specialty drugs for which prior approval has been denied or not obtained* • *Anti-narcolepsy, ADD/ADHD, and certain analgesic/opiod medications for which prior approval has been denied or not obtained* • *Certain compounding chemicals (over-the-counter (OTC) products, bulk powders, bulk chemicals, and proprietary bases)* • *Certain topical analgesics for the temporary relief of minor aches and muscle pains that may be marketed contrary to the Federal Food, Drug and Cosmetic Act (the FD&C Act)* *Note: See Section 5(h).* Wellness and Other Special Features *for information on the Enhanced CaremarkDirect Retail 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 Self Plus One enrollment or $600 per Self and Family enrollment).
- 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, laboratory, electrocardiogram (ECG/EKG), electroencephalogram (EEG), the administration of anesthesia and the emergency room visit billed by non-PPO providers at the PPO benefit level, based on Plan allowance, if the services are rendered at a PPO hospital or PPO ambulatory surgical center.
- Be sure to read Section 4. *Your Costs for Covered Services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

What is an accidental dental injury?

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

What is a sound natural tooth?

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

Benefit Description	You pay
Note: The calendar year deductible applies ONLY when we say, "(calendar year deductible applies)."	
Accidental dental injury benefit	
We only cover outpatient dental treatment incurred and completed within 72 hours of an accidental injury (as defined above). We provide benefits for services, supplies, or appliances (such as space maintainers) for dental care necessary to repair injury to sound natural teeth (as defined above) required as a result of, and directly related to, an accidental injury.	PPO: 15% of the Plan allowance Non-PPO: 30% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Not covered: • *Dental services not rendered or completed within 72 hours* • *Bridges, oral implants, dentures, crowns* • *Orthodontic treatment* • *Night splint/guard*	*All charges*

Section 5(h). Wellness and Other Special Features

Special feature	Description
24-hour help line for mental health and substance use disorder	You may call 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 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.nalchbp.org
Childhood Weight Management Resource Center	Visit our website at www.nalchbp.org 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 online 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.
Diabetes care management program – Transform Diabetes Care	This program helps deliver better overall care and lower costs for members with diabetes. It includes a connected glucometer, unlimited test strips and lancets, medication therapy counseling from a pharmacist, two annual diabetes screenings at a CVS MinuteClinic® and a suite of digital resources through the CVS mobile App, all at no cost. Please call CVS Caremark® at 800-933-NALC (6252) for more information.
Disease management program - Gaps in Care	This program integrates medical, pharmacy, and laboratory data to identify and address members' gaps in care. Gaps in care occur when individuals do not receive or adhere to care that is consistent with medically proven guidelines for prevention or treatment. This is an outreach program for both you and your physician. Members and their physicians are informed by mail of potential gaps and are instructed on how to improve adherence to existing therapies. Some examples of conditions that are managed through the program are: diabetes, hypertension, and cardiac disorders.
Disease management program - Your Health First	Through a clinical identification process, individuals are identified who have a chronic health condition such as asthma, COPD, depression, diabetes, or heart disease. Health advocates trained as nurses, coaches, nutritionists, and clinicians use a one-on-one approach to help individuals: • Recognize worsening symptoms and know when to see a doctor • Establish questions to discuss with their doctor • Understand the importance of following doctors' orders • Develop health habits related to nutrition, sleep, exercise, weight, tobacco, and stress • Prepare for a hospital admission or recover after a hospital stay • Make educated decisions about treatment options You may call 877-220-NALC (6252) to speak to a health advocate.

Special feature	Description
Enhanced CaremarkDirect Retail Program	You can purchase non-covered drugs through your local CVS network pharmacy and receive the convenience, safety, and confidentiality you already benefit from with covered prescriptions. Our Enhanced CaremarkDirect Retail is offered at no additional charge to you. Using this program at your local CVS Pharmacy, as well as all major chains, for both covered and non-covered prescriptions will help ensure overall patient safety. The program allows you to get a discount on many prescription drugs not covered by our prescription benefit. Enhanced CaremarkDirect Retail 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 800-933-NALC (6252), 24 hours a day, 7 days a week, for a complete listing of available medications and their cost.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Health Assessment	A free Health Assessment is available under Quicklinks at www.nalchbp.org. The Health Assessment is an online program that analyzes your health related responses and gives you a personalized plan to achieve specific health goals. Your Health Assessment profile provides information to put you on a path to good physical and mental health. • When one covered member completes the Health Assessment, you may choose one of the following: - Self only Cigna*Plus* Savings® discount dental program. We will pay the Cigna*Plus* Savings® discount dental premium for the remainder of the calendar year in which you completed the Health Assessment provided you remain enrolled in our Plan; - Waiver of two $20 PPO medical office visit copayments (when the Plan is the primary payor) incurred in the same year as the Health Assessment is completed. Copayment waivers will be applied to claims for services rendered after completion of the Health Assessment; or - A wearable activity tracking device.

	• When two or more covered family members (including the member) complete the Health Assessment, you may choose one of the following: - Family Cigna*Plus* Savings® discount dental program. We will pay the Cigna*Plus* Savings® discount dental premium for the remainder of the calendar year in which you completed the Health Assessment provided you remain enrolled in our Plan; - Waiver of four $20 PPO medical office visit copayments (when the Plan is the primary payor) incurred in the same year as the Health Assessment is completed. Copayment waivers will be applied to claims for services rendered after completion of the Health Assessment; or - A wearable activity tracking device (limit 2 devices per enrollment). **Note:** You must be 18 years or older to be eligible to complete the Health Assessment. Individuals age 13 and older can access other services offered by CareAllies/Cigna. Cigna*Plus* Savings® is a discount dental program that provides members access to discounted fees with participating dental providers. For more information on this program, call 877-521-0244 or visit www.cignaplussavings.com.
Healthy Pregnancies, Healthy Babies Program	This is a voluntary program for all expectant mothers. You will receive educational information and support throughout your entire pregnancy and after. You will speak to a pregnancy specialist and receive unlimited coaching calls to provide you with caring support to optimize your chances of having a healthy, full-term pregnancy. There will be ongoing assessments to help with early detection of a high risk pregnancy or other special needs you may have during your pregnancy. Healthy Pregnancies, Healthy Babies will work together with you and your doctor to develop a plan of care. After delivery, you will also be screened for signs of postpartum depression. Call 877-220-6252 to enroll in the Healthy Pregnancies, Healthy Babies program as soon as you know you are pregnant.
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, and healthy lifestyle products. This program promotes wellness, good health, and healthy behaviors. For more information call 800-558-9443 or visit our website at www.nalchbp.org.
Personal Health Record	Our Personal Health Record allows you to create and maintain a complete, comprehensive, and confidential medical record containing information on allergies, immunizations, medical providers, medications, past medical procedures, and more. Participation is voluntary and access is secured. To access, register at www.nalchbp.org, log on and select the 'Personal Health Record' tab.
Services for deaf and hearing impaired	TTY lines are available for the following: CVS Caremark®: 800-238-1217 (prescription benefit information) OptumHealth Behavioral Solutions: 800-842-2479 (mental health and substance use disorder information)
Solutions for Caregivers	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 have the option to purchase continuing services beyond the six hours offered. You must call 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. You may also access educational resources and discounted products and services anytime online at www.UHCforCaregivers.com/welcome/nalchbp. Please use code NALCHBP when creating an account.
Specialty Connect	This enhanced service combines the services of CVS Pharmacy and CVS Specialty™ by offering expanded choices and greater access to specialty medications and services. Specialty prescriptions can be submitted to any local CVS Pharmacy or to our Specialty mail pharmacies. Members will receive telephonic clinical support from our Specialty pharmacy Care Team and will have the added option to pick up their specialty medication at a CVS Pharmacy or to have them delivered to the location of their choice. Call 800-237-2767 for more information.
Substance Use Disorder (SUD) Program	This program offers assistance in finding In-Network providers and treatment options in the area and provides education about the SUD condition. Call Optum™ at 855-780-5955 to speak with a licensed clinician who can help guide you to an In-Network treatment provider or treatment center. Better treatment outcomes occur when you have a clear individualized treatment plan within your community.
Substance Use Disorder (SUD) Care Management Program	This clinical care management outreach program through Optum™ provides ongoing support for those individuals impacted by substance use. Participants are assigned a master's level clinician to provide phone based support and advocacy including, but not limited to: • Toxicology screening • Meetings with patient's family • Referral management and appointment setting • Mobile App with patient portal and real-time care plan tracking • Unlimited after hours support for both patients and family members • Regular reporting This program is designed to engage participants in successful recovery by developing the best treatment options and guiding the participants to the right care.
Weight Management Program	The Weight Talk® Program through Optum™ is a personal coaching program designed to achieve measurable, sustainable weight loss. It is delivered through regular phone-based coaching sessions with a dedicated coach. Participants set realistic weight goals and through small multiple behavior changes learn how to achieve and maintain a healthy weight for the rest of their lives.

	Participants receive scheduled telephone coaching sessions with a dedicated coach or registered dietitian. Participants also have lifetime access to weight loss tools, educational resources and community support on the Weight Talk® website. Each participant receives a Welcome Kit containing a weight loss workbook, food journal, tape measure and a wireless activity monitor that tracks and uploads steps, calories burned, distance traveled, and activity duration wirelessly to the Weight Talk® website. This allows participants to track their activity history on the website and allows coaches to see the participants' progress throughout the course of the program. Individuals can enroll in the Weight Talk® Program online at www.nalchbp.org or call the toll-free number at 844-305-0758. A personal dedicated coach is available 7 days a week from 5:00 a.m. to 9:00 p.m. Pacific time.
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.*

Consumer Driven Health Plan/Value Option Benefits

See page 200 for a benefits summary.

Consumer Driven Health Plan/Value Option Overview

The Plan offers a Consumer Driven Health Plan (CDHP) High and Value Option Plan. The CDHP benefit package is described in this section. Make sure that you review the benefits that are available under the benefit option in which you are enrolled.

Section 5, which describes the CDHP/Value Option benefits, is divided into subsections. Please read the *Important things you should keep in mind* about these benefits at the beginning of each subsection. Also read the general exclusions in Section 6. These exclusions apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about CDHP/Value Option benefits, contact us at 855-511-1893 or on our website at www.nalchbp.org.

This CDHP/Value Option focuses on you, the health care consumer, and gives you greater control in how you use your health care benefits. With this Plan, eligible In-Network preventive care is covered in full. The Traditional Medical Coverage begins after you satisfy your deductible.

You can use the Personal Care Account (PCA) for any covered care. If you exhaust your PCA, the Traditional Medical Coverage begins after you satisfy the calendar year deductible. If you don't exhaust your PCA for the year, you can roll it over to the next year, up to the maximum rollover balance amount, as long as you continue to be enrolled in the CDHP/Value Option. The Personal Care Account (PCA) is described in Section 5.

The CDHP/Value Options include:

In-Network Preventive Care

This component covers 100% for preventive care for adults and children if you use an In-Network provider. The covered services include office visits/exams, immunizations and screenings and are fully described in Section 5.

CDHP/Value Option Personal Care Account (PCA)

The Plan also provides a PCA for each enrollment in the CDHP/Value Option. Each year, the Plan provides members $1,200 for a Self Only, $2,400 for a Self Plus One or $2,400 for a Self and Family who enroll in the CDHP during Open Season and $100 for a Self Only, $200 for a Self Plus One, or $200 for a Self and Family who enroll in the Value Option during Open Season. The PCA amount is subject to a monthly proration for enrollments outside of Open Season. Eligibility for the Plan's PCA is determined on the first day of the month of your effective day of enrollment in the CDHP or Value Option Plan and will be prorated for the length of the enrollment. See Section 5. *CDHP/Value Option Personal Care Account* for enrollments outside of Open Season.

If you join the CDHP Self Only and then switch to CDHP Self Plus One or CDHP Self and Family, the PCA will increase from $1,200 to $2,400. We will deduct any amounts used while under the CDHP Self Only from the CDHP Self Plus One or CDHP Self and Family of $2,400.

If you join the CDHP Self Plus One or CDHP Self and Family and later switch to CDHP Self Only, the PCA will decrease from $2,400 to $1,200. We will deduct amounts of the PCA previously used while enrolled in the CDHP Self Plus One or CDHP Self and Family from the CDHP Self Only amount of $1,200. For example, if $500 of the Self and Family PCA has been used and you change to CDHP Self Only, the PCA will be $1,200 minus $500 or $700 for the remainder of the year. **A member changing their enrollment option will not be penalized for amounts used while in the CDHP Self Plus One or CDHP Self and Family that exceed the amount of the CDHP Self Only PCA.**

If you join the Value Option Self Only and then switch to Value Option Self Plus One or Value Option Self and Family, the PCA will increase from $100 to $200. We will deduct any amounts used while under the Value Option Self Only from the Value Option Self Plus One or Value Option Self and Family of $200.

If you join the Value Option Self Plus One or Value Option Self and Family and later switch to Value Option Self Only, the PCA will decrease from $200 to $100. We will deduct amounts of the PCA previously used while enrolled in the Value Option Self Plus One or Value Option Self and Family from the Value Option Self Only amount of $100. For example, if $50 of the Self and Family PCA had been used and you change to Value Option Self Only coverage, the PCA will be $100 minus $50 or $50 for the remainder of the year. **A member changing their enrollment option will not be penalized for amounts used while in the Value Option Self Plus One or Value Option Self and Family that exceed the amount of the Value Option Self Only PCA.**

Traditional Health Coverage

If you are enrolled in the CDHP/Value Option, you must satisfy your calendar year deductible and exhaust your Personal Care Account (PCA) before the Plan starts paying benefits under the Traditional Health Coverage described in Section 5(c).

The Plan generally pays 80% of the cost for In-Network care and 50% of the Plan allowance for Out-of-Network care.

Wellness and Other Special Features

Section 5(h). describes the wellness and other special features available to you under the CDHP/Value Option to help you improve the quality of your health care and manage your expenses. There is also customer care support and a 24-hour nurse advisory service.

Section 5. CDHP/Value Option Personal Care Account

Important things you should keep in mind about your Personal Care Account (PCA) for the CDHP andValue Option:

- All eligible health care expenses (except In-Network preventive care) are paid first from your PCA. Traditional Health Coverage (under CDHP and Value Option Section 5) will only start once the PCA is exhausted.
- Note that In-Network preventive care covered under the CDHP and Value Option Section 5 does NOT count against your PCA.
- The CDHP and Value Option PCA provides full coverage for both In-Network and Out-of-Network providers. However, your PCA will generally go much further when you use network providers because network providers agree to discount their fees.
- The Plan provides you with the resources to manage your PCA. You can track your PCA on your personal private website through mycigna.com, by telephone at 855-511-1893, or with monthly statements mailed directly to you at home.
- If you join the CDHP during Open Season, you receive the full PCA $1,200 for Self Only, $2,400 for Self Plus One,or $2,400 for Self and Family as of your effective date of coverage. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $100 per month for Self Only or $200 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- If you join Value Option during Open Season, you receive the full PCA of $100 per Self Only, $200 for Self Plus One, or $200 per Self and Family as of your effective date of coverage. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $8.33 per month for Self Only or $16.67 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- Unused PCA benefits are forfeited when leaving this Plan.
- If PCA benefits are available in your account at the time a claim is processed, out-of-pocket expenses will be paid from your PCA regardless of the date the expense was incurred.
- 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.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

Benefit description	You pay
There is no calendar year deductible for In-Network preventive care under the CDHP/Value Option.	
Personal Care Account for CDHP and Value Option	
A CDHP Personal Care Account (PCA) is provided by the Plan for each Open Season enrollment. See the Important section for enrollments outside of Open Season. Each full year the Plan adds to your account: • $1,200 per year for Self Only • $2,400 per year for Self Plus One or • $2,400 per year for Self and Family The CDHP PCA covers eligible expenses at 100%. For example, if you are ill and go to a network doctor for a $60 visit, the doctor will submit your claim and the cost of the visit will be deducted automatically from your PCA; you pay nothing. Balance in CDHP PCA for Self Only $1,200 Less: Cost of visit -60 Remaining Balance in CDHP PCA $1,140 A Value Option PCA is provided by the Plan for each enrollment. Each year the Plan adds to your account: • $100 per year for Self Only • $200 per year for Self Plus One or • $200 per year for Self and Family The PCA covers eligible expenses at 100%. For example, if you are ill and go to a network doctor for a $60 visit, the doctor will submit your claim and the cost of the visit will be deducted automatically from your PCA; you pay nothing. Balance in Value Option Plan PCA for Self Only $100 Less: Cost of visit -60 Remaining Balance in Value Option PCA Account $ 40 **Note: PCA** expenses are the same medical, surgical, hospital, emergency, mental health and substance use disorder, and prescription drug services and supplies covered under the Traditional Health Coverage (see CDHP and Value Option, Section 5 for details) To make the most of your PCA you should: • Use network providers wherever possible; and • Use generic prescriptions wherever possible.	CDHP In-Network and Out-of-Network: Nothing up to $1,200 for Self Only, $2,400 for Self Plus One, or $2,400 for Self and Family Value Option In-Network and Out-of-Network: Nothing up to $100 for Self Only, $200 for Self Plus One, or $200 for Self and Family

Personal Care Account for CDHP and Value Option - continued on next page

Benefit description	You pay
Personal Care Account for CDHP and Value Option (cont.)	
Not covered: • *Orthodontia* • *Dental treatment for cosmetic purposes including teeth whitening* • Out-of-network preventive care services *not included under CDHP Section 5(a)* • *Services or supplies shown as not covered under* Traditional Health Coverage *(see CDHP and Value Option Section 5(c)*	*All charges*

PCA

Rollover

As long as you remain in this Plan, any unused remaining balance in your PCA at the end of the calendar year may be rolled over to subsequent years. The maximum amount allowed in your PCA in any given year may not exceed $5,000 for Self Only, $10,000 for Self Plus One, or $10,000 for Self and Family.

Section 5. Traditional Health Coverage

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.
- When you enroll in a Consumer Driven Health Plan (CDHP) during Open Season, we will give you a Personal Care Account (PCA) credit in the amount of $1,200 for Self Only, $2,400 for Self Plus One, or $2,400 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $100 per month for Self Only or $200 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- When you enroll in the Value Option during Open Season, we will give you a Personal Care Account (PCA) credit in the amount of $100 for Self Only, $200 for Self Plus One, or $200 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $8.33 per month for Self Only or $16.67 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- In-Network Preventive Care is covered at 100% under CDHP/Value Option and does not count against your PCA when you are enrolled in the CDHP/Value Option.
- Your PCA must be used first for eligible healthcare expenses when you are enrolled in the CDHP/Value Option.
- Your deductible applies to all benefits in this section. When you are enrolled in the CDHP/Value Option and your PCA has exhausted, you must meet your deductible before your Traditional Health Coverage may begin.
- The CDHP/Value Option provides coverage for both In-Network and Out-of-Network providers. The Out-of-Network benefits are the standard benefits under the Traditional Health Coverage. In-Network benefits apply only when you use an In-Network provider. When an In-network provider is not available, Out-of-Network benefits apply.
- Please keep in mind that when you use an In-Network hospital or an In-Network physician, some of the professionals that provide related services may **not** all be preferred providers. If they are not, they will be paid as Out-of-Network providers.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost- sharing works. Also read Section 9 for information about how we pay if you have other coverage or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

Benefit Description	You pay	
Deductible before Traditional Health Coverage begins (CDHP/Value Option)	**CDHP**	**Value Option**
If you are enrolled in the CDHP/Value Option and your PCA has exhausted, you must satisfy your calendar year deductible before your Traditional Health Coverage begins.		

Deductible before Traditional Health Coverage begins (CDHP/Value Option) - continued on next page

Benefit Description	You pay	
Deductible before Traditional Health Coverage begins (CDHP/Value Option) (cont.)	**CDHP**	**Value Option**
Your deductible is $2,000 for Self Only, $4,000 for Self Plus One, or $4,000 for Self and Family for In-Network providers. Your deductible for Out-of-Network providers is $4,000 for Self Only, $8,000 for Self Plus One, or $8,000 for Self and Family. See Section 4. *Your Costs for Covered Services* for more information. Note: You must use any available PCA benefits, including any amounts rolled over from previous years, before Traditional Health Coverage begins when you are enrolled in the CDHP/Value Option. See the table below for how your PCA and deductible work.		

CDHP	Self Only	Self Plus One	Self and Family
Expenses paid by PCA	$1,200	$2,400	$2,400
Deductible paid by you	$800	$1,600	$1,600
Traditional Health Coverage starts after	$2,000	$4,000	$4,000

CDHP: Any PCA dollars that you rollover at the end of the year will reduce your deductible next year up to the maximum amount allowed in your PCA of $5,000 for Self Only, or $10,000 for Self Plus One, or $10,000 for Self and Family. In future years, the amount of your deductible may be lower if you rollover PCA dollars at the end of the year. For example, if you rollover $300 at the end of the year:	In-Network: $800 per Self Only, $1,600 per Self Plus One, or $1,600 per Self and Family Out-of-Network: $2,800 per Self Only, $5,600 per Self Plus One, or $5,600 per Self and Family The “You pay” shown above may be reduced for year 2 due to any rollover amount in your PCA.	

Deductible before Traditional Health Coverage begins (CDHP/Value Option) - continued on next page

Benefit Description				You pay	
Deductible before Traditional Health Coverage begins (CDHP/Value Option) (cont.)				**CDHP**	**Value Option**
CDHP	Self Only	Self Plus One	Self and Family	In-Network: $800 per Self Only, $1,600 per Self Plus One, or $1,600 per Self and Family Out-of-Network: $2,800 per Self Only, $5,600 per Self Plus One, or $5,600 per Self and Family The "You pay" shown above may be reduced for year 2 due to any rollover amount in your PCA.	
PCA for year 2 Rollover from year 1	$1,200 +$300 $1,500	$2,400 +$300 $2,700	$2,400 +$300 $2,700		
Deductible paid by you	+ $500	+ $1,300	+ $1,300		
Traditional Health Coverage starts when eligible expenses total	$2,000	$4,000	$4,000		
Value Option	Self Only	Self Plus One	Self and Family		In-Network: $1,900 per Self Only, $3,800 per Self Plus One, or $3,800 per Self and Family Out-of-Network: $3,900 per Self Only, $7,800 per Self Plus One, or $7,800 per Self and Family Note: The "You pay" shown above may be reduced for year 2 due to any rollover amount in your PCA
Expenses paid by PCA	$100	$200	$200		
Deductible paid by you	$1,900	$3,800	$3,800		
Traditional Health Coverage starts after	$2,000	$4,000	$4,000		

Value Option:

Any PCA dollars that you rollover at the end of the year will reduce your deductible next year up to the maximum amount allowed in your PCA of $5,000 for Self Only, $10,000 for Self Plus One, or $10,000 for Self and Family.

Deductible before Traditional Health Coverage begins (CDHP/Value Option) - continued on next page

Benefit Description	You pay	
Deductible before Traditional Health Coverage begins (CDHP/Value Option) (cont.)	**CDHP**	**Value Option**
In future years, the amount of your deductible may be lower if you rollover PCA dollars at the end of the year. For example, if you rollover $50 at the end of the year:		In-Network: $1,900 per Self Only, $3,800 per Self Plus One, or $3,800 per Self and Family Out-of-Network: $3,900 per Self Only, $7,800 per Self Plus One, or $7,800 per Self and Family Note: The "You pay" shown above may be reduced for year 2 due to any rollover amount in your PCA

Value Option	Self Only	Self Plus One	Self and Family
PCA for year 2 Rollover from year 1	$100 +$50 $150	$200 +$50 $250	$200 +$50 $250
Deductible paid by you	+ $1,750	+$3,750	+ $3,750
Traditional Health Coverage starts when eligible expenses total	$2,000	$4,000	$4,000

Section 5. Preventive Care

Important things you should keep in mind about these In-Network preventive care 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.
- Under the CDHP/Value Option, the Plan pays 100% for the Preventive Care services listed in this Section as long as you use an In-Network provider.
- For preventive care not listed in this Section or for preventive care from an Out-of-Network provider, please see CDHP/Value Option Section 5. *Personal Care Account* when you are enrolled in the CDHP/Value Option.
- For all other covered expenses, please see CDHP/Value Option Section 5. *Traditional Health Coverage*. If you are enrolled in CDHP/Value Option also see CDHP/Value Option Section 5. *Personal Care Account*.
- Note that the In-Network preventive care paid under this Section does NOT count against or use up your Personal Care Account (PCA) when you are enrolled in the CDHP/Value Option.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage or if you are age 65 or over.
- Please keep in mind that when you use an In-Network hospital or In-Network physician, some of the professionals that provide related services may **not** all be In-Network providers. If they are not, they will be paid as Out-of-Network providers.

Benefit Description	You pay	
Note: There is no calendar year deductible for In-Network preventive care under the CDHP/Value Option.		
Preventive care, adult	**CDHP**	**Value Option**
Routine examinations, limited to: • Routine physical exam—one annually, age 22 or older • Initial office visit associated with a covered routine sigmoidoscopy or colonoscopy screening test	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)
For a complete list of adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule please visit our website, www.nalchbp.org. Note: When the NALC Health Benefit Plan CDHP/Value Option 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.nalchbp.org or call CVS Caremark® Customer Service at 800-933-NALC (6252) to locate a local participating pharmacy.	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**CDHP**	**Value Option**
Screenings, limited to: • Abdominal aortic aneurysm screening by ultrasonography—one in a lifetime, for men age 65 through 75 with smoking history • Alcohol and drug use disorder screening—age 22 and older • Basic or comprehensive metabolic panel blood test—one annually • Biometric screening- one annually; including: - calculation of body mass index (BMI) - waist circumference measurement - total blood cholesterol - blood pressure check - fasting blood sugar • Chest x-ray—one annually • Colorectal cancer screening for adult age 50 through 75, including: - Fecal occult blood test—one annually - Fecal immunochemical test (FIT)—one annually - Computed tomographic (CT) colonography—one every 5 years - Double contrast barium enema (DCBE)—one every 5 years - Stool based DNA such as ColoGuard—one every 3 years - Sigmoidoscopy screening—one every 5 years - Colonoscopy screening—(with or without polyp removal)—one every 10 years • Complete Blood Count (CBC)—one annually • Depression screening—age 18 and older • Diabetes screening—as recommended by the U.S. Preventive Services Task Force (USPSTF) • Electrocardiogram (ECG/EKG)—one annually • Fasting lipoprotein profile (total cholesterol, LDL, HDL, and triglycerides)—one every five years, age 20 and older • General health panel blood test—one annually • Hepatitis B virus infection screening—for adults at high risk for infection as recommended by the U.S. Preventive Services Task Force (USPSTF) • Hepatitis C virus infection screening: - One – for adults born between 1945 and 1965	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**CDHP**	**Value Option**
- For adults at high risk for infection as recommended by the U.S. Preventive Services Task Force (USPSTF) • High blood pressure screening—as recommended by the U.S. Preventive Services Task Force (USPSTF) • Human Immunodeficiency Virus (HIV)—adults age 65 and younger • Lung Cancer screening with low-dose Computerized Tomography (LDCT Scan)—one annually for adults age 55 through 80 who have a 30 pack-year smoking history and currently smoke or have quite within the past 15 years • 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) • Tuberculosis screening for adults at increased risk, age 18 and older • Urinalysis—one annually • Well-woman care based on current recommendations such as: - 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) - Cervical cancer screening (Pap smear) age 21 to age 65—one annually - Chlamydial infection test - Contraception counseling with reproductive capability as prescribed - Counseling for sexually transmitted infections - Counseling and screening for human immunodeficiency virus for sexually active women - Gonorrhea screening limited to: • Women age 24 and younger • Women age 25 and older at increased risk as recommended by the U.S. Preventive Services Task Force (USPSTF) - Human papillomavirus (HPV) testing age 30 through age 65—one every three years - Osteoporosis screening limited to: • Women age 40 - 64 at increased risk as recommended by the U.S. Preventive Services Task Force (USPSTF)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**CDHP**	**Value Option**
• Women age 65 and older - Postpartum diabetes mellitus screening for women with a history of gestational diabetes mellitus - Routine 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 - Screening and counseling for interpersonal and domestic violence - Screening for urinary incontinence Note: Additional well women preventive care services may be listed separately in this section. Note: Breast tomosynthesis (3-D mammogram) is considered a preventive care screening test as long as it is performed in conjunction with a routine screening mammography. Note: We cover a preventive medicine counseling associated with a low-dose Computerized Tomography (LDCT) scan—one annually.	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)
Preventive medicine counseling by a covered primary care provider as recommended by the U.S. Preventive Services Task Force (USPSTF), limited to: • Alcohol use disorder • Aspirin use for the prevention of cardiovascular disease • Breast cancer chemoprevention • Depression • Fall prevention—age 65 and older • Obesity (includes dietary counseling for adults at higher risk for chronic disease) • Sexually transmitted infections • Skin cancer prevention for adults age 24 and younger • Tobacco use Note: See CDHP/Value Option 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.	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)

Preventive care, adult - continued on next page

Benefit Description	You pay	
Preventive care, adult (cont.)	**CDHP**	**Value Option**
Note: See CDHP/Value Option Section 5 (f). *Prescription Drug Benefits* for a listing of preventive medications available to promote better health as recommended under the ACA. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayment, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org. HHS: www.healthcare.gov/preventive-care-benefits/ CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services**:** www.healthcare.gov/preventive-care-women/ For additional information: www.healthfinder.gov/myhealthfinder/default.aspx	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)
Not covered: • *Routine lab tests, except listed under* Preventive care, adult *in this section.* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*	*All charges*
Preventive care, children	**CDHP**	**Value Option**
• Well-child visits, examinations, and immunizations as described in the Bright Futures Guidelines provided by the American Academy of Pediatrics • Examinations, limited to: - Initial examination of a newborn child covered under a family enrollment - Well-child care—routine examinations through age 2 - Routine physical exam (including camp, school, and sports physicals)—one annually, age 3 through 21 - Examinations done on the day of covered immunizations, age 3 through 21	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**CDHP**	**Value Option**
• For a complete list of childhood immunizations covered through age 21, please see the American Academy of Pediatrics Bright Futures Guidelines at brightfutures.aap.org/Pages/default.aspx or visit our website at www.nalchbp.org. Note: When the NALC Health Benefit Plan CDHP/Value Option 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.nalchbp.org or call CVS Caremark® Customer Service at 800-933-NALC (6252) to locate a local participating pharmacy. Screenings, limited to: • Alcohol and drug use assessment as recommended by Bright Futures/AAP—age 11 through 21 • Chlamydial infection test • Depression screening as recommended by the U.S. Preventive Services Task Force (USPSTF)—age 12 through 17 • Developmental screening (including screening for autism spectrum disorder) as recommended by Bright Futures/AAP—through age 3 • Developmental surveillance and behavioral assessment as recommended by Bright Futures/AAP—age 21 and younger • Fasting lipoprotein profiles (total cholesterol, LDL, HDL and triglycerides): - One, age 9 through 11 - One, age 18 through 21 - Age 17 and younger with medical indications as recommended by Bright Futures/AAP • Gonorrhea screening—as recommended by the U. S. Preventive Services Task Force (USPSTF) • Hearing screening: - Age 3-10 - For those at high risk as recommended by Bright Futures/AAP, through age 21 • Hemoglobin/hematocrit - One, at ages: 12 months, 15 months and 30 months - One annually, for females age 11 through 21	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**CDHP**	**Value Option**
• Hepatitis B virus infection screening—for adolescents at high risk for infection as recommended by the U.S. Preventive Services Task Force (USPSTF) • High blood pressure screening as recommended by the U.S. Preventive Services Task Force (USPSTF) • Human Immunodeficiency Virus (HIV): - Age 15 and older - Age 14 and younger at increased risk as recommended by the U.S. Preventive Services Task Force (USPSTF) • Lead screening test—age 6 and younger with medical indications as recommended by Bright Futures/AAP • Newborn metabolic screening panel—one, age 2 months and younger • Newborn screening hearing test—one in a lifetime • Newborn screening test for congenital hypothyroidism, phenylketonuria (PKU) and sickle cell—one in a lifetime • Obesity screening in children and adolescents age 6 through 21 • Oral health assessment - one, ages 12 months and 18 months - one, annually through age 6 • Annual routine pap test for females age 21 and older • Sexually transmitted infections screening as recommended by Bright Futures/AAP – children age 11 and older • Syphilis screening for children age 11 and older as recommended by the U.S. Preventive Services Task Force (USPSTF) • Tuberculosis screening – for those at high risk as recommended by Bright Futures/AAP, through age 21 • Urinalysis—one annually, age 5 through 21 • Vision screening for amblyopia or its risk factors (limited to: strabismus, astigmatism, anisometropia, and hyperopia) as recommended by the U.S. Preventive Services Task Force (USPSTF) and Bright Futures/AAP—one annually, age 3 through 5 • Vision screening as recommended by Bright Futures/AAP, age 6 through 18	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**CDHP**	**Value Option**
Note: For the coverage of the initial newborn exam see *Diagnostic and treatment services* in CDHP/Value Option Section 5(a). Preventive medicine counseling by a covered primary care provider as recommended by the U.S. Preventive Services Task Force (USPSTF), limited to: • Alcohol and drug use disorder screening—age 18 through 21 • Anemia • Application of fluoride varnish to primary teeth by a covered primary care provider—age 5 and younger • Dental cavities • Major depressive disorder	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)
• Obesity • Sexually transmitted infections • Skin cancer prevention • Tobacco use Note: See Section 5(f). *Prescription Drug Benefits* for a listing of preventive medications available to promote better health as recommended under the ACA. Note: Any procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at www.uspreventiveservicestaskforce.org. HHS: www.healthcare.gov/prevention CDC: www.cdc.gov/vaccines/schedules/index.html Women's preventive services: www.healthcare.gov/preventive-care-women/ For additional information: www.healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)

Preventive care, children - continued on next page

Benefit Description	You pay	
Preventive care, children (cont.)	**CDHP**	**Value Option**
Note: See CDHP/Value Option Section 5(a). *Educational classes and programs* for more information on educational classes and nutritional therapy for self management of diabetes, hyperlipidemia, hypertension, and obesity.	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)	In-Network: Nothing Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount. (calendar year deductible applies)
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*	*All charges*

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.
- When you enroll in the CDHP during Open Season, we will give you a Personal Care Account (PCA) in the amount of $1,200 for Self Only, $2,400 for Self Plus One, or $2,400 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $100 per month for Self Only or $200 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- When you enroll in the Value Option during Open Season, we will give you a PCA in the amount of $100 for Self Only, $200 for Self Plus One, or $200 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $8.33 per month for Self Only or $16.67 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- In-Network Preventive Care is covered at 100% under Section 5 and does not count against your PCA when you are enrolled in the CDHP/Value Option Plan.
- Your PCA must be used first for eligible healthcare expenses when you are enrolled in the CDHP/Value Option Plan.
- If your PCA has been exhausted, you must meet your deductible before your Traditional Health Coverage may begin.
- Your deductible applies to almost all benefits in this Section. We say "(No deductible)" when the deductible does not apply.
- The CDHP/Value Option provide coverage for both In-Network and Out-of-Network providers. The Out-of-Network benefits are the standard benefits under the Traditional Health Coverage. In-Network benefits apply only when you use an In-Network provider. When an In-Network provider is not available, Out-of-Network benefits apply.
- Please keep in mind that when you use an In-Network hospital or an In-Network physician, some of the professionals that provide related services may **not** all be preferred providers. If they are not, they will be paid as Out-of-Network providers.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to precertification information in Section 3 to be sure which procedures require precertification.
- **YOU MUST GET PRIOR AUTHORIZATION FOR APPLIED BEHAVIORAL ANALYSIS (ABA) THERAPY.** FAILURE TO DO SO WILL RESULT IN A DENIAL OF BENEFITS. Please refer to prior authorization information in Section 3.
- **YOU MUST GET PRIOR APPROVAL FOR GENETIC TESTING**. FAILURE TO DO SO WILL RESULT IN A DENIAL OF BENEFITS. Please refer to prior authorization information in Section 3.

Benefit Description	You pay After the calendar year deductible. . .	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when the deductible does not apply.		
Diagnostic and treatment services	**CDHP**	**Value Option**
Professional services of physicians (including specialists) or urgent care centers • Office or outpatient visits • Office or outpatient consultations • Second surgical opinions	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Professional services of physicians • Hospital care • Skilled nursing facility care • Inpatient medical consultations • Home visits Note: For initial examination of a newborn child covered under a family enrollment, see *Preventive care, children* in CDHP/Value Option Section 5. Note: For routine post-operative surgical care, see CDHP/Value Option Section 5(b). *Surgical procedures*.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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 CDHP/Value Option Section 5)* • *Nonsurgical treatment for weight reduction or obesity (except as listed in* Educational classes and programs *in this section)*	*All charges*	*All charges*
Lab, x-ray and other diagnostic tests	**CDHP**	**Value Option**
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) • Genetic testing	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Lab, x-ray and other diagnostic tests - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Lab, x-ray and other diagnostic tests (cont.)	**CDHP**	**Value Option**
Note: Benefits are available for diagnostic genetic testing when it is medically necessary to diagnose and/or manage a patient's medical condition. Genetic testing requires prior authorization. See Section 3. *How You Get Care*.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: Routine tests, except listed under Preventive care, adult *in Section 5.*	*All charges*	*All charges*
Maternity care	**CDHP**	**Value Option**
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	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Breastfeeding support and counseling • Rental of breastfeeding equipment	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Screening tests as recommended by the USPSTF for pregnant women, limited to: • Depression screening • Gestational diabetes for pregant women • Hepatitis B • Human Immunodeficiency Virus (HIV) • Iron deficiency anemia • Preeclampsia screening • 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: • Lactation support and counseling for breastfeeding	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: Nothing (No deductible) Out-of-Network: 50% 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 the calendar year deductible. . .	
Maternity care (cont.)	**CDHP**	**Value Option**
• Tobacco use counseling	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Other tests medically indicated for the unborn child or as part of the maternity care Note: Here are some things to keep in mind: • Genetic tests performed as part of a routine pregnancy require prior authorization • You do not need to precertify your vaginal or cesarean 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 vaginal 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 Self Plus One or Self and Family enrollment. • The circumcision charge for an infant covered under Self Plus One or Self and Family enrollment is payable under surgical benefits. See CDHP/ Value Option Section 5(b). *Surgical procedures*. • We pay hospitalization, anesthesia, and surgeon services for non-maternity care the same as for illness and injury. • Hospital services are covered under CDHP/Value Option Section 5(c) and Surgical benefits under CDHP/Value Option Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible. . .	
Family Planning	**CDHP**	**Value Option**
Voluntary family planning services, limited to: • Voluntary female sterilization • Surgical placement of implanted contraceptives • Insertion of intrauterine devices (IUDs) • Administration of an injectable contraceptive drug (such as Depo provera) • Removal of a birth control device • Management of side effects of birth control • Services related to follow up of services listed above • Office visit associated with a covered family planning service Note: Outpatient facility charges related to voluntary female sterilization is payable under outpatient hospital benefit. See CDHP/Value Option Section 5 (c). *Outpatient hospital.* For anesthesia related to voluntary female sterilization, see CDHP/Value Option Section 5(b). *Anesthesia.* Note: We cover oral contraceptives and injectable contraceptive drugs (such as Depo provera) only under the Prescription drug benefit. See CDHP/Value Option Section 5(f). *Prescription Drug Benefits.*	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Vasectomy (see CDHP/Value Option Section 5(b). *Surgical procedures*)	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling except as listed in this section.*	*All charges*	*All charges*
Infertility services	**CDHP**	**Value Option**
Diagnosis and treatment of infertility, except as shown in *Not covered.* Limited benefits: We pay a $2,500 calendar year maximum per person to diagnose or treat infertility.	In-Network: 20% of the Plan allowance and all charges after we pay $2,500 in a calendar year Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after we pay $2,500 in a calendar year	In-Network: 20% of the Plan allowance and all charges after we pay $2,500 in a calendar year Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after we pay $2,500 in a calendar year

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Infertility services (cont.)	**CDHP**	**Value Option**
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures such as:* - *Artificial insemination (AI)* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *Intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Prescription drugs for infertility*	*All charges*	*All charges*
Allergy care	**CDHP**	**Value Option**
• Testing • Treatment • Allergy serum • Allergy injections	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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*	*All charges*
Treatment therapies	**CDHP**	**Value Option**
• Intravenous (IV)/Infusion Therapy—Home IV and antibiotic therapy • Respiratory and inhalation therapies • Growth hormone therapy (GHT) • Cardiac rehabilitation therapy - Phases I and II only	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Treatment therapies (cont.)	**CDHP**	**Value Option**
Note: Phase I begins in the hospital after a major heart event and includes visits by the cardiac rehab team, education, and nutritional counseling, along with rehab. Phase II begins after leaving the hospital and is a comprehensive program consisting of medical evaluation, prescribed exercise, behavior modification, heart monitoring, education, and counseling, typically performed in an outpatient setting. Phases III and IV are supervised safe exercise (performed in the home or gym) and are not covered by the Plan. Note: Specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs, available through CVS Specialty™ are covered only under the Prescription drug benefit. See CDHP/Value Option 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 CDHP/Value Option 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 CDHP/Value Option Section 5(b). *Organ/tissue transplants.* Note: Oral chemotherapy drugs available through CVS Caremark® are covered only under the Prescription Drug Benefit. See CDHP/Value Option Section 5(f). *Prescription Drug Benefits—These are the dispensing limitations.*	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Applied Behavioral Analysis (ABA) therapy for autism spectrum disorder rendered by an In-Network provider: - Age 3 through 11 up to 15 hours per week - Age 12 through 18 up to 9 hours per week Note: Prior authorization is required for ABA therapy. Call 855-511-1893 to find a covered provider and to obtain prior authorization.	In-Network: 20% of the Plan allowance Out-of-Network: All charges	In-Network: 20% of the Plan allowance Out-of-Network: All charges
Not covered: • *Chelation therapy, except as treatment for acute arsenic, gold, lead, or mercury poisoning* • *Prolotherapy*	*All charges*	*All charges*

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Treatment therapies (cont.)	**CDHP**	**Value Option**
• *School-based ABA therapy* • *ABA therapy covered by Medicaid under the Individuals with Disabilities Education Act (IDEA)* • *ABA therapy not prior authorized*	*All charges*	*All charges*
Physical, occupational, and speech therapies	**CDHP**	**Value Option**
• A combined total of 50 rehabilitative and habilitative 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.	In-Network: 20% of the Plan allowance and all charges after 50 visit limit Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after 50 visit limit	In-Network: 20% of the Plan allowance and all charges after 50 visit limit Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after 50 visit limit
Note: For accidental injuries, see CDHP/Value Option Section 5(d). *Emergency Services/Accidents*. Note: For therapies performed on the same day as outpatient surgery, see CDHP/Value Option 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.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Physical therapy to prevent falls for community-dwelling adults age 65 and older as recommended by the U.S. Preventive Services Task Force (USPSTF) Therapy is covered when the attending physician: • Orders the care; • Identifies the specific professional skills the patient requires; and • Indicates the length of time the services are needed.	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Exercise programs* • *Maintenance rehabilitative therapy that maintains a functional status or prevents decline in function*	*All charges*	*All charges*

Benefit Description	You pay After the calendar year deductible. . .	
Hearing services (testing, treatment, and supplies)	**CDHP**	**Value Option**
• 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	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Hearing aid and related examination for neurosensory hearing loss limited to a maximum Plan payment of $500 per ear with replacements covered every 3 years.	In-Network: 20% of the Plan allowance and all charges after we pay $500 per ear Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after we pay $500 per ear	In-Network: 20% of the Plan allowance and all charges after we pay $500 per ear Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after we pay $500 per ear
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 CDHP/Value Option Section 5* • *Hearing aid and examination, except as described above* • *Auditory device except as described above*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**CDHP**	**Value Option**
• Office visit for eye examinations for covered diagnoses, such as cataract, diabetic retinopathy and glaucoma	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount

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

Benefit Description	You pay After the calendar year deductible. . .	
Vision services (testing, treatment, and supplies) (cont.)	**CDHP**	**Value Option**
Note: We only cover the standard intraocular lens prosthesis, such as for cataract surgery. Note: For childhood preventive vision screenings see *Preventive care, children* in Section 5. Note: See CDHP/Value Option Section *5(h). Wellness and Other Special Features* for discounts available for vision care.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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*	*All charges*
Foot care	**CDHP**	**Value Option**
• Nonsurgical routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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)	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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*	*All charges*

Benefit Description	You pay After the calendar year deductible. . .	
Orthopedic and prosthetic devices	**CDHP**	**Value Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • 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 CDHP/Value Option Section 5(b). *Surgical procedures*. For information on the hospital and/or ambulatory surgery center benefits, see CDHP/Value Option 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 CDHP/Value Option 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.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• One pair of custom functional foot orthotics, including casting, every 5 years when prescribed by a physician (with a maximum Plan payment of $200).	In-Network: 20% of the Plan allowance and all charges after we pay $200 Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after we pay $200	In-Network: 20% of the Plan allowance and all charges after we pay $200 Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after we pay $200
Not covered: • *Wigs (cranial prosthetics)* • *Orthopedic and corrective shoes* • *Arch supports, heel pads and heel cups* • *Foot orthotics (shoe inserts) except as listed under* Orthopedic and prosthetic devices *in this section* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*	*All charges*

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Orthopedic and prosthetic devices (cont.)	**CDHP**	**Value Option**
• *Bionic prosthetics (including microprocessor-controlled prosthetics)* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*	*All charges*
Durable medical equipment (DME)	**CDHP**	**Value Option**
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 855-511-1893 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	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered:	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Durable medical equipment (DME) (cont.)	**CDHP**	**Value Option**
• *DME replacements (including rental) provided less than 3 years after the last one we covered* • *Sun or heat lamps, whirlpool baths, saunas, shower chairs, commode chairs, shower commode chairs, and similar household equipment* • *Safety, convenience, and exercise equipment, such as treadmills, exercise bicycles (including functional electrical stimulation equipment), stair climbers, and free weights* • *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 126*	*All charges*	*All charges*
Home health services	**CDHP**	**Value Option**
Home nursing care for 2 hours per day up to 25 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.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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*	*All charges*	*All charges*

Home health services - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Home health services (cont.)	**CDHP**	**Value Option**
• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*
Chiropractic	**CDHP**	**Value Option**
Limited to: • One set of spinal x-rays annually • 12 spinal or extraspinal manipulations per calendar year Note: When spinal and extraspinal manipulations are performed on the same day, each manipulation applies to the calendar year maximum.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Limited to: • Initial office visit or consultation • 12 office visits per calendar year when rendered on the same day as a covered spinal or extraspinal manipulation	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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*	*All charges*
Alternative treatments	**CDHP**	**Value Option**
Limited to: • Initial office visit or consultation to assess patient for acupuncture treatment	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Limited to: • Acupuncture, by a doctor of medicine or osteopathy, or a state licensed or certified acupuncturist. Benefits are limited to 12 acupuncture visits per person per calendar year.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after 12 visit limit	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount and all charges after 12 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*	*All charges*

Benefit Description	You pay After the calendar year deductible. . .	
Educational classes and programs	**CDHP**	**Value Option**
Coverage includes: • A voluntary tobacco cessation program offered by the Plan which includes: - Unlimited professional 20-30 minute telephonic counseling sessions per quit attempt - Online tools - Over-the-counter nicotine replacement therapy For more information on the program or to join, visit www.mycigna.com or call 855-246-1873. 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 CDHP/Value Option Section 5(f). *Prescription Drug Benefits*.	In-Network: Nothing for services obtained through the tobacco cessation program offered by the CDHP/Value Option (No deductible)	In-Network: Nothing for services obtained through the tobacco cessation program offered by the CDHP/Value Option (No deductible)
• Educational classes and nutritional therapy for diabetes, obesity, and overweight individuals with risk factors for cardiovascular disease (such as: abnormal fasting glucose levels, hyperlipidemia, hypertension, and metabolic syndrome) 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 CDHP/Value Option Section 5(h). *Wellness and Other Special Features*.	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Over-the-counter medications or dietary supplements prescribed for weight loss* • *Prescription medications prescribed for weight loss*	*All charges*	*All charges*

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.
- When you enroll in the Consumer Driven Health Plan during Open Season, we will give you a Personal Care Account (PCA) in the amount of $1,200 for Self Only, $2,400 for Self Plus One, or $2,400 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $100 per month for Self Only or $200 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- When you enroll in the Value Option during Open Season, we will give you a PCA in the amount of $100 for Self Only, $200 for Self Plus One, or $200 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $8.33 per month for Self Only or $16.67 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- In-Network Preventive Care is covered at 100% under Section 5 and does not count against your PCA when you are enrolled in the CDHP/Value Option.
- Your PCA must be used first for eligible healthcare expenses when you are enrolled in the CDHP/Value Option Plan.
- If your PCA has been exhausted, you must meet your deductible before your Traditional Health Coverage may begin.
- Your deductible applies to almost all benefits in this Section. We say "(No deductible)" when the deductible does not apply.
- The CDHP/Value Option provides coverage for both In-Network and Out-of-Network providers.
- The Out-of-Network benefits are the standard benefits under the Traditional Health Coverage. In-Network benefits apply only when you use an In-Network provider. When an In-Network provider is not available, Out-of-Network benefits apply.
- Please keep in mind that when you use an In-Network hospital or an In-Network physician, some of the professionals that provide related services may **not** all be preferred providers. If they are not, they will be paid as Out-of-Network providers.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost- sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See CDHP/Value Option 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 CDHP/Value Option Section 5(b). *Organ/tissue transplants*.
- **YOU MUST GET PRIOR APPROVAL FOR SPINAL SURGERIES PERFORMED IN AN INPATIENT OR OUTPATIENT SETTING**. **Call 855-511-1893 to obtain prior approval.**
- **YOU MUST GET PRIOR APPROVAL FOR GENDER REASSIGNMENT SURGERY. FAILURE TO DO SO WILL RESULT IN A DENIAL OF BENEFITS. See Section 3. *How You Get Care.***
- **Not all surgical procedures require prior approval.** You may contact Cigna at 855-511-1893 to determine coverage for the surgical procedure prior to the service being rendered.

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 the deductible does not apply.		
Surgical procedures	**CDHP**	**Value Option**
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 CDHP/Value Option Section 5(a). *Orthopedic and prosthetic devices*, for device coverage information. • Vasectomy • Debridement of burns	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• 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 at least one clinically significant obesity-related co-morbidity including, but not limited to: weight-related degenerative joint disease, type 2 diabetes, cardiovascular disease, hypertension, obstructive sleep apnea, hyperlipidemia, or debilitating arthritis. 2. Diagnosis of morbid obesity for a period of one year prior to surgery. 3. The patient has participated in a supervised weight-loss program of at least six months duration, that includes dietary therapy, physical activity, and behavioral modification. Evidence in the medical record that attempts at weight loss in the one year period prior to surgery have been ineffective. 4. The patient is age 18 or older. 5. Medical and psychological evaluations have been completed and the patient has been recommended for bariatric surgery. 6. A repeat or revised bariatric surgical procedure is covered only when determined to be medically necessary or a complication has occurred. • Gender reassignment surgical benefits are limited to the following:	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After calendar year deductible. . .	
Surgical procedures (cont.)	**CDHP**	**Value Option**
- For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, and placement of an erectile prosthesis - For male to female surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, and labiaplasty Note: Prior approval is required for gender reassignment surgery. For more information about prior approval, please refer to Section 3. *How You Get Care*. Note: Your provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and your provider later modifies the plan. Note: Benefits for gender reassignment surgery are limited to once per covered procedure, per lifetime. Benefits are not available for repeat or revision procedures when benefits were provided for the initial procedure. Benefits are not available for gender reassignment surgery for any condition other than gender dysphoria. • Gender reassignment surgery on an inpatient or outpatient basis is subject to the pre-surgical requirements listed below. **The patient must meet all requirements.** - Prior approval is obtained - Patient must be at least 18 years of age at the time prior approval is requested and the treatment plan is submitted - Diagnosis of gender dysphoria by a qualified healthcare professional • Patient's gender dysphoria is not a symptom of another mental disorder • Gender dysphoria causes clinical distress or impairment in social, occupational, or other important areas of functioning - Patient must meet the following criteria: • Documentation the individual has lived for at least 12 continuous months in a gender role that is congruent with their gender identity (including place of employment, family, social and community activities) • 12 months of continuous hormone therapy appropriate to the patient's gender identity	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You pay After calendar year deductible. . .	
Surgical procedures (cont.)	**CDHP**	**Value Option**
• Two referral letters from mental health professionals (Master's level or more advanced degree from an accredited institution) to include a letter of recommendation for the procedure • If medical or mental health concerns are present, they are being optimally managed and are reasonably well-controlled - Reversal of a gender reassignment surgery is covered only when determined to be medically necessary or a complication occurs. 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).	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
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.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Voluntary female sterilization • Surgical placement of implanted contraceptives • Insertion of intrauterine devices (IUDs) • Removal of birth control device Note: We cover intrauterine devices and implanted contraceptives, (such as Implanon) only under the Prescription Drug Benefit. See CDHP/Value Option Section 5(f). *Prescription Drug Benefits.*	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: Nothing (No deductible) Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Oral implants and transplants*	*All charges*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You pay After calendar year deductible. . .	
Surgical procedures (cont.)	**CDHP**	**Value Option**
• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone)* • *Cosmetic surgery, except for repair of accidental injury if repair is initiated within six months after an accident; correction of a congenital anomaly; or breast reconstruction following a mastectomy* • *Radial keratotomy and other refractive surgery* • *Procedures performed through the same incision deemed incidental to the total surgery, such as appendectomy, lysis of adhesion, puncture of ovarian cyst* • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standby surgeons are medically necessary* • *Cutting, trimming, or removal of corns, calluses, or the free edge of toenails; and similar routine treatment of conditions of the foot, except as listed under CDHP/Value Option Section 5(a).* Foot care • *Weight loss surgery for implantable devices such as Maestro Rechargeable System*	*All charges*	*All charges*
Reconstructive surgery	**CDHP**	**Value Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - The condition produced a major effect on the member's appearance; and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a congenital anomaly (condition that existed at or from birth and is a significant deviation from the common form or norm). Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birthmarks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts - Treatment of any physical complications, such as lymphedemas Note: Congenital anomaly does not include conditions related to teeth or intra-oral structures supporting the teeth.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You pay After calendar year deductible. . .	
Reconstructive surgery (cont.)	**CDHP**	**Value Option**
Note: We cover internal and external breast prostheses, surgical bras and replacements. See CDHP/Value Option Section 5(a). *Orthopedic and prosthetic devices*, and CDHP/Value Option 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.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
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* • *Surgery related to sexual dysfunction (except gender reassignment surgeries specifically listed as covered)*	*All charges*	*All charges*
Oral and maxillofacial surgery	**CDHP**	**Value Option**
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)	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone).*	*All charges*	*All charges*

Benefit Description	You pay After calendar year deductible. . .	
Organ/tissue transplants	**CDHP**	**Value Option**
Cigna ***Life***SOURCE Transplant Network® - The Plan participates in the Cigna ***Life***SOURCE Transplant Network®. Before your initial evaluation as a potential candidate for a transplant procedure, you or your physician must contact Cigna HealthCare at 855-511-1893 and speak to a referral specialist in the Comprehensive Transplant Case Management Unit. You will be given information about this program including a list of participating providers. Charges for services performed by a Cigna ***Life***SOURCE Transplant Network® provider, whether incurred by the recipient or the donor, are paid at 80% 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.	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network®
Limited Benefits—If you do not obtain prior approval or do not use a designated facility, or if we are not the primary payor, we pay a maximum of $100,000 for each listed transplant (kidney limit, $50,000), for these combined expenses: pre-transplant evaluation; organ procurement; and inpatient hospital, surgical and medical expenses. We pay benefits according to the appropriate benefit section, such as CDHP/Value Option Section 5(c). *Inpatient hospital*, and *Surgical procedures* in this section. The limitation applies to expenses incurred by either the recipient or donor. Note: Some transplants listed may not be covered through the Cigna ***Life***SOURCE Transplant Network®. Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.	In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount	In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount
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: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After calendar year deductible. . .	
Organ/tissue transplants (cont.)	**CDHP**	**Value Option**
- Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney/pancreas • Liver • Lung single/bilateral/lobar • Pancreas	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount
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.	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount
• Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. 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:	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After calendar year deductible. . .	
Organ/tissue transplants (cont.)	**CDHP**	**Value Option**
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Advanced neuroblastoma - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteoporosis - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, 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 - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - X-linked lymphoproliferative syndrome • Autologous transplants for: - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After calendar year deductible. . .	
Organ/tissue transplants (cont.)	**CDHP**	**Value Option**
- Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount
Blood or marrow stem cell transplants covered only in a National Cancer Institute (NCI) or National Institutes of Health (NIH) approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols limited to: • Autologous transplants for: - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma), adult T-cell leukemia/ lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms - 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.	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After calendar year deductible. . .	
Organ/tissue transplants (cont.)	**CDHP**	**Value Option**
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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - 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 recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (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.	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount	20% of the Plan allowance for services obtained through the Cigna ***Life***SOURCE Transplant Network® In-Network: 30% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our Plan allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You pay After calendar year deductible. . .	
Organ/tissue transplants (cont.)	**CDHP**	**Value Option**
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*	*All charges*
Anesthesia	**CDHP**	**Value Option**
Professional services provided in: • Hospital (inpatient)	In-network: 20% of the Plan allowance Out-of-network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-network: 20% of the Plan allowance Out-of-network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Professional services provided in: • Hospital outpatient department • Ambulatory surgical center • Office • Other outpatient facility	In-network: 20% of the Plan allowance Out-of-network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-network: 20% of the Plan allowance Out-of-network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Professional services provided for: • Voluntary female sterilization	In-network:Nothing (No deductible) Out-of-network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-network: Nothing (No deductible) Out-of-network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- When you enroll in the CDHP during Open Season, we will give you a Personal Care Account (PCA) in the amount of $1,200 for Self Only, $2,400 for Self Plus One, or $2,400 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $100 per month for Self Only or $200 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- When you enroll in the Value Option during Open Season, we will give you a PCA in the amount of $100 for Self Only, or $200 for Self Plus One, or $200 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $8.33 per month for Self Only or $16.67 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- In-Network Preventive Care is covered at 100% under CDHP/Value Option Section 5 and does not count against your PCA when you are enrolled in the CDHP/Value Option plan.
- Your PCA must be used first for eligible healthcare expenses when you are enrolled in the CDHP/Value Option plan.
- If your PCA has been exhausted, you must meet your deductible before your Traditional Health Coverage may begin.
- Your deductible applies to almost all benefits in this Section. We say "(No deductible)" when the deductible does not apply.
- The CDHP/Value Option provide coverage for both In-Network and Out-of-Network providers.
- The Out-of-Network benefits are the standard benefits under the Traditional Health Coverage. In-Network benefits apply only when you use a network provider. When a network provider is not available, Out-of-Network benefits apply.
- Please keep in mind that when you use an In-Network hospital or an In-Network physician, some of the professionals that provide related services may **not** all be preferred providers. If they are not, they will be paid as Out-of-Network providers.
- 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 CDHP/Value Option Sections 5(a) or (b) for costs associated with the professional charge (i.e., physicians, etc.).
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You pay After the calendar year deductible. . .	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when the deductible does not apply.		
Inpatient hospital	**CDHP**	**Value Option**
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.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Note: When the non-PPO hospital bills a flat rate, we will exclude all charges and request an itemized bill. Note: When room and board charges are billed by a hospital, inpatient benefits apply. For **observation** room charges billed, see *Outpatient hospital or ambulatory surgical center* in this section.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • 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	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Inpatient hospital - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Inpatient hospital (cont.)	**CDHP**	**Value Option**
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 CDHP/Value Option 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.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Take-home items: • Medical supplies, appliances, and equipment; and any covered items billed by a hospital for use at home	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
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*	*All charges*

Benefit Description	You pay After the calendar year deductible. . .	
Outpatient hospital or ambulatory surgical center	**CDHP**	**Value Option**
Services and supplies, such as: • Observation, operating, recovery, and other treatment rooms • Prescribed drugs and medications • 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 CDHP/Value Option Section 5(a). *Physical, occupational, and speech therapies* for coverage of these therapies. Note: For accidental injuries, see CDHP/Value Option Section 5(d). *Emergency Services/Accidents*. Note: We cover hospital services and supplies related to dental procedures when necessitated by a nondental physical impairment. We do not cover the dental procedures or the anesthesia service when billed by the anesthesiologist. Note: Specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs dispensed in an outpatient hospital are subject to the Specialty Drug copayment. See *Outpatient hospital or ambulatory surgical center*, in this section.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Outpatient services and supplies for the delivery of a newborn	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Outpatient services and supplies for a voluntary female sterilization	In-Network: Nothing (No deductible)	In-Network: Nothing (No deductible)

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Outpatient hospital or ambulatory surgical center (cont.)	**CDHP**	**Value Option**
	Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Plan pays for pre-operative testing within 7 days of surgery. Screening tests, limited to: • Chest x-rays • Electrocardiograms • Urinalysis • Blood work Note: Diagnostic tests, such as magnetic resonance imaging, throat cultures, or similar studies are not considered as preadmission testing.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• Specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs Note: Prior approval is required for all specialty drugs used to treat chronic medical conditions. Call CVS Specialty™ at 800-237-2767 to obtain prior approval, more information, or a complete list.	In-Network: • 30-day supply: $200 • 90-day supply: $400 Out-of-Network: • 30-day supply: $200 and the difference, if any, between our Plan allowance and the charged amount • 90-day supply: $400 and the difference, if any, between our Plan allowance and the charged amount	In-Network: • 30-day supply: $200 • 90-day supply: $400 Out-of-Network: • 30-day supply: $200 and the difference, if any, between our Plan allowance and the charged amount • 90-day supply: $400 and the difference, if any, between our Plan allowance and the charged amount
Not covered: Personal comfort items	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**CDHP**	**Value Option**
No benefit	*All charges*	*All charges*
Hospice care	**CDHP**	**Value Option**
No benefit	*All charges*	*All charges*
Ambulance	**CDHP**	**Value Option**
• 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.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount

Ambulance - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Ambulance (cont.)	**CDHP**	**Value Option**
Note: When ambulance transportation to the nearest PPO facility is provided by a non-PPO provider, we will pay up to the Plan allowance at the PPO benefit level.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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 ambulance transportation to the nearest PPO facility is provided by a non-PPO provider, we will pay up to the Plan allowance at the PPO benefit level.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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*	*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.
- When you enroll in the Consumer Driven Health Plan (CDHP) during Open Season, we will give you a Personal Care Account (PCA) in the amount of $1,200 for Self Only, $2,400 for Self Plus One, or $2,400 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $100 per month for Self Only or $200 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- When you enroll in the Value Option during Open Season, we will give you a Personal Care Account (PCA) in the amount of $100 for Self Only, $200 for Self Plus One, or $200 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $8.33 per month for Self Only or $16.67 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- In-Network Preventive Care is covered at 100% under CDHP/Value Option plans and does not count against your PCA.
- Your PCA must be used first for eligible healthcare expenses when you are enrolled in the CDHP/Value Option.
- If your PCA has been exhausted, you must meet your deductible before your Traditional Health Coverage may begin.
- Your deductible applies to all benefits in this Section.
- The CDHP/Value Option provides coverage for both In-Network and Out-of-Network providers.
- The Out-of-Network benefits are the standard benefits under the Traditional Health Coverage. In-Network benefits apply only when you use a network provider. When a network provider is not available, Out-of-Network benefits apply.
- Please keep in mind that when you use an In-Network hospital or an In-Network physician, some of the professionals that provide related services may **not** all be preferred providers. If they are not, they will be paid as Out-of-Network providers.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also read Section 9 for information about how we pay if you have other coverage or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

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

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

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

Benefit Description	You pay After the calendar year deductible . . .	
Accidental injury	**CDHP**	**Value Option**
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 CDHP/Value Option Section 5(b). *Surgical procedures.* Note: We pay inpatient professional and hospital benefits when you are admitted. See CDHP/Value Option Section 5(a). *Diagnostic and treatment services,* CDHP/Value Option Section 5(b). *Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professions,* and CDHP/Value Option Section 5(c). *Services Provided by a Hospital or Other Facility, and ambulance services.*	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Services received after 72 hours	Medical and outpatient hospital benefits apply. See CDHP/Value Option Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals*, CDHP/Value Option Section 5(b). *Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals* and CDHP/Value Option Section 5(c). *Outpatient hospital or ambulatory surgical center* for the benefits we provide.	Medical and outpatient hospital benefits apply. See CDHP/Value Option Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care professionals*, CDHP/Value Option Section 5(b). *Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals* and CDHP/Value Option Section 5(c). *Outpatient hospital or ambulatory surgical center* for the benefits we provide.
Medical emergency	**CDHP**	**Value Option**
Outpatient hospital medical emergency service for a medical emergency condition	In-Network: 20% of the Plan allowance Out-of-Network: 20% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 20% of the Plan allowance and the difference, if any, between our allowance and the billed amount.

Medical emergency - continued on next page

Benefit Description	You pay After the calendar year deductible . . .	
Medical emergency (cont.)	**CDHP**	**Value Option**
	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.	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 Surgical services. See CDHP/Value Option Section 5(b). *Surgical procedures.*	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Ambulance	**CDHP**	**Value Option**
Local professional ambulance service when medically necessary 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. Note: When ambulance transportation to the nearest PPO facility is provided by a non-PPO provider, we will pay up to the Plan allowance at the PPO benefit level.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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*	*All charges*

Section 5(e). Mental Health and Substance Use Disorder Benefits

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

When you receive care, you must get our approval for services. If you do, cost-sharing and limitations for mental health and substance use disorder benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things to keep in mind about these benefits:

- When you enroll in the CDHP during Open Season, we give you a Personal Care Account (PCA) in the amount of $1,200 for Self Only, $2,400 for Self Plus One, or $2,400 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $100 per month for Self Only or $200 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- When you enroll in the Value Option during Open Season, we will give you a PCA in the amount of $100 for Self Only, $200 for Self Plus One, or $200 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $8.33 per month for Self Only or $16.67 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- Your PCA must be used first for eligible healthcare expenses when you are enrolled in the CDHP/ Value Option plan.
- If your PCA has been exhausted, you must meet your deductible before your Traditional Health Coverage may begin.
- Your deductible applies to all benefits in this Section.
- The CDHP/Value Option provide coverage for both In-Network and Out-of-Network providers.
- The Out-of-Network benefits are the standard benefits under Traditional Health Coverage. In-Network benefits apply only when you use a network provider. When a network provider is not available, Out-of-Network benefits apply.
- Please keep in mind that when you use an In-Network hospital or an In-Network physician, some of the professionals that provide related services may **not** all be preferred providers. If they are not, they will be paid as Out-of-Network providers.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.

Benefit Description	You pay After the calendar year deductible . . .	
In-Network and Out-of-Network benefits	**CDHP**	**Value Option**
• Outpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Outpatient medication management Note: Applied Behavioral Analysis (ABA) therapy benefit is listed in Section 5(a). *Medical Services and Supplies Provided by Physicians and Other Health Care Professionals.*	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• 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. Note: When ambulance transportation to the nearest PPO facility is provided by a non-PPO provider, we will pay up to the Plan allowance at the PPO benefit level.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% 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. Note: When ambulance transportation to the nearest PPO facility is provided by a non-PPO provider, we will pay up to the Plan allowance at the PPO benefit level.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
• 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 as partial hospitalization, half-way house, residential treatment, full-day hospitalization, and facility based intensive outpatient treatment	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance, if any, between our allowance and the billed amount

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

Benefit Description	You pay After the calendar year deductible . . .	
In-Network and Out-of-Network benefits (cont.)	**CDHP**	**Value Option**
Residential Treatment Center (RTC) - Precertification prior to admission is required. A preliminary treatment plan and discharge plan must be developed and agreed to by the member, provider (residential treatment center (RTC)), and case manager prior to admission. We cover inpatient care provided and billed by an RTC for members enrolled and participating in an approved plan of care, and when the care is medically necessary for treatment of a medical, mental health, and/or substance use condition: • Room and board, such as semiprivate room, nursing care, meals, special diets, ancillary charges, and covered therapy services when billed by the facility. Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, halfway house, schools, or similar type facility. Note: Benefits are not available for non-covered services, including: respite care; outdoor residential programs; wilderness treatment or services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services; custodial or long term care and domiciliary care provided because care in the home is not available or is unsuitable.	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount	In-Network: 20% of the Plan allowance Out-of-Network: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount
Not covered: • *Treatment for learning disabilities and intellectual disabilities* • *Treatment for marital discord* • *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: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*	*All charges*

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

Benefit Description	You pay After the calendar year deductible . . .	
In-Network and Out-of-Network benefits (cont.)	**CDHP**	**Value Option**
Note: Exclusions that apply to other benefits apply to these mental health and substance use disorder benefits.	*All charges*	*All charges*

Precertification

Call 855-511-1893 to locate In-Network clinicians who can best meet your needs.

For services that require precertification, you must follow all of the following network precertification processes:

- Call 855-511-1893 to receive precertification for an inpatient hospital stay when we are your primary payor. You and your provider will receive written confirmation of the precertification from Cigna Behavioral Health for the initial and any ongoing authorizations.

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

- When Medicare is your primary payor, call Cigna at 855-511-1893 to precertify 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 precertify treatment when Medicare covers your services.

Where to file claims

Claims should be submitted to:

NALC CDHP or Value Option
PO BOX 188050
Chattanooga, TN 37422-8050
Questions? 855-511-1893

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

Section 5(f). Prescription Drug Benefits

Important things to keep in mind about these benefits:

- When you enroll in the CDHP during Open Season, we will give you a Personal Care Account (PCA) in the amount of $1,200 for Self Only, $2,400 for Self Plus One, or $2,400 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $100 per month for Self Only or $200 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- When you enroll in the Value Option during Open Season, we will give you a PCA in the amount of $100 for Self Only, or $200 for Self Plus One, or $200 for Self and Family. If you join at any other time during the year, your PCA for your first year will be prorated at a rate of $8.33 per month for Self Only or $16.67 per month for Self Plus One or Self and Family for each full month of coverage remaining in that calendar year.
- Your PCA must be used first for eligible healthcare expenses when you are enrolled in the CDHP/ Value Option Plan.
- If your PCA has been exhausted, you must satisfy your calendar year deductible before your Traditional Health Coverage may begin.
- Your deductible applies to almost all benefits in this Section. We say "(No deductible)" when the deductible does not apply.
- We cover prescribed medications and supplies as described in the chart beginning on page 158.
- 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.
- Federal law prevents the pharmacy from accepting unused medications.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- **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 888-636-NALC (6252) for authorization.
- Be sure to read Section 4. *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, licensed or certified Physician Assistant, Nurse practitioner and Psychologist must prescribe your medication.
- **Where you can obtain them.** You may fill the prescription at a 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.
  - **Network pharmacy**—Present your Plan identification card at an NALC CareSelect Network pharmacy to purchase prescription drugs. Call 800-933-NALC (6252) to locate the nearest network pharmacy.
  - **Non-network pharmacy—**You may purchase prescriptions at pharmacies that are not part of our network. You pay full cost and must file a claim for reimbursement. See *When you have to file a claim* in this Section.

- **Mail order—**Complete the patient profile/order form. Send it along with your prescription(s) and payment, in the preaddressed envelope to:

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

- **We use a formulary.** A formulary is a list of prescription drugs, both generic and brand name, that provide a safe, effective and affordable alternative to non-formulary drugs, which have a higher cost-share. Our formulary is open and voluntary. It is called the NALC Health Benefit Plan Drug List. If your physician believes a brand name drug is necessary, or if there is no generic available, ask your physician to prescribe a formulary brand name drug from our NALC Health Benefit Plan Formulary Drug List. You will pay the appropriate retail coinsurance and mail order copayment amounts for generic and formulary brand name drugs on this list. Your out-of-pocket costs will be higher for non-formulary brand name drugs not on the NALC Health Benefit Plan Formulary Drug List. To order this list, call 800-933-NALC (6252).
- **These are the dispensing limitations.**
  - For prescriptions purchased at NALC CareSelect pharmacies you may obtain up to a 30-day fill plus one refill.
  - Maintenance and long-term medications may be ordered through our Mail Order Prescription Drug Program for up to a 90-day supply (21-day minimum). The 21-day minimum does not apply to specialty drugs ordered through CVS Specialty™.
  - 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.

Most prescriptions can be filled after 75% of the drug has been used. However, individual pharmacists may refuse to fill or refill a prescription if there is a question about the order's accuracy, validity, authenticity, or safety to the patient, based on the pharmacists professional judgement. 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 generally include, but may not be limited to, drugs and biologics (medications created from living cells cultured in a laboratory) that may be complex to manufacture, can have routes of administration more challenging to administer (injectable, infused, inhaled, topical, and oral), may have special handling requirements, may require special patient monitoring, and may have special programs mandated by the FDA to control and monitor their use. These drugs are typically used to treat chronic, serious, or life-threatening conditions. Examples of such conditions include, but are not limited to, myelogenous leukemia (AML), cancer, Crohn’s disease, cystic fibrosis, growth hormone disorder, hemophilia, hepatitis C, HIV, immune deficiencies, multiple sclerosis, osteoarthritis, psoriasis, and rheumatoid arthritis. Specialty drugs are often priced much higher than traditional drugs.

- All specialty drugs require preauthorization and may include step therapy; call CVS Specialty™ at 800-237-2767. Our benefit includes the Advanced Control Specialty Formulary that includes a step therapy program and uses evidence-based protocols that require the use of a preferred drug(s) before non-preferred specialty drugs are covered. The Advanced Control Specialty Formulary is designed as a specialty drug formulary that includes generics and clinically effective brands as determined through clinical evidence. The therapy classes chosen for Advanced Control Specialty Formulary have multiple specialty drugs available that are considered therapeutically equivalent (similar safety and efficacy), thus providing the opportunity to utilize the lowest cost drug(s). In addition, categories, therapies and tiering changes could be updated every quarter and added to the formulary. Please refer to the Advance Control Specialty formulary drug list for more information about the drugs and classes.
- All specialty drugs must be purchased through CVS Specialty™.
- Some specialty medications may qualify for third party copayment assistance programs which could lower your out-of-pocket costs for those medications. When specialty medication is purchased with a third party copayment assistance coupon, rebate, or card, the Plan will not apply the amount of the discount towards your out-of-pocket maximum or deductible.

- The Specialty Connect feature allows you to submit your specialty medication prescription to your local CVS Pharmacy. See Section 5(h). *Wellness and Other Special Features* or call 800-237-2767 for more information.

Note: Decisions about prior approval are based on evidence-based guidelines developed by CVS Caremark® Pharmacy's clinical team and include, but are not limited to, FDA approved indications and/or independent expert panels.

We require prior authorization (PA) for certain drugs to ensure safety, clinical appropriateness and cost effectiveness. PA criteria is designed to determine coverage and help to promote safe and appropriate use of medications. To obtain a list of drugs that require PA, please visit our website, www.nalchbp.org or call 888-636-NALC (6252).

- **All anti-narcolepsy, ADD/ADHD, certain analgesics and certain opioid medications require prior authorization. Call CVS Caremark® at 800-933-NALC (6252) to obtain prior authorization.**

A compound drug is a medication made by combining, mixing or altering ingredients in response to a prescription, to create a customized drug that is not otherwise commercially available. Certain compounding chemicals (over-the-counter (OTC) products, bulk powders, bulk chemicals and proprietary bases) are not covered through the prescription benefit will be determined through preauthorization. Refill limits may apply.

- **All compound drugs require prior authorization. Call CVS Caremark® at 800-933-NALC (6252) to obtain authorization.**
- **A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name.** If you receive a brand name drug when a federally-approved generic drug is available, and your physician has not specified "Dispense as Written" for the brand name drug, you have to pay the difference in cost between the brand name drug and the generic.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name. The brand name is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic drug costs you—and us—less than a brand name drug.
- **When you have Medicare Part D.** We waive the following at retail when Medicare Part D is primary payor and covers the drug:
  - Refill limitations
  - Day supply

Note: See Section 9. *Coordinating Benefits with Medicare and Other Coverage*, for more information on Medicare Part D.

- **When you have to file a claim.** If you purchase prescriptions at a non-network pharmacy, foreign/overseas pharmacy, or elect to purchase additional 30-day refills at a network pharmacy, complete the short-term prescription claim form. Mail it with your prescription receipts to the NALC Prescription Drug Program. Receipts must include the patient's name, prescription number, medication 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**,** and made a payment, we will pay as secondary up to our Plan limit. If no payment is made by the primary payor, complete the short-term prescription claim form, attach the drug receipts and other carrier's reason for denial 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 an NALC CareSelect Network retail pharmacy, or need additional claim forms, call 800-933-NALC (6252) 24 hours a day, 7 days a week.

Benefit Description	You pay After the calendar year deductible. . .	
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when the deductible does not apply.		
Covered medications and supplies	**CDHP**	**Value Option**
You may purchase the following medications and supplies from a pharmacy or by mail: • Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that by federal law of the United States require a physician's prescription for their purchase, except as shown in *Not covered* • Insulin • Needles and syringes for the administration of covered medications • Drugs for sexual dysfunction, when the dysfunction is caused by medically documented organic disease • Vitamins and minerals that by federal law of the United States require a physician's prescription for their purchase Note: You may purchase up to a 90-day supply (84-day minimum) of covered drugs and supplies at a CVS Caremark® Pharmacy through our Maintenance Choice Program. You will pay the applicable mail order copayment for each prescription purchased. Note: We will waive the one 30-day fill and one refill limitation at retail for patients confined to a nursing home, patients who are in the process of having their medication regulated, or when state law prohibits the medication from being dispensed in a quantity greater than 30 days. Call the Plan at 888-636-NALC (6252) to have additional refills at a network retail pharmacy authorized. Note: For coverage of the Herpes Zoster (shingles) vaccine, see CDHP/Value Option Section 5(a). *Preventive care, adult.*	Retail: • Network retail: - Generic: $10 ($5 for hypertension, diabetes, and asthma) - Formulary brand: $40 - Non-formulary brand: $60 • Non-network retail: 50% of the Plan allowance, and the difference, if any, between our allowance and the billed amount Mail order: • 90-day supply: - Generic: $20 ($13 for hypertension, diabetes, and asthma) - Formulary brand: $80 ($70 for hypertension, diabetes, and asthma) - Non-formulary brand: $120 ($110 for hypertension, diabetes, and asthma) 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 Network pharmacy without prior Plan authorization. This does not include prescriptions purchased at a CVS Caremark® Pharmacy through our Maintenance Choice Program.	Retail: • Network retail: - Generic: $10 ($5 for hypertension, diabetes, and asthma) - Formulary brand: $40 - Non-formulary brand: $60 • Non-network retail: 50% of the Plan allowance, and the difference, if any, between our allowance and the billed amount Mail order: • 90-day supply: - Generic: $20 ($13 for hypertension, diabetes, and asthma) - Formulary brand: $80 ($70 for hypertension, diabetes, and asthma) - Non-formulary brand: $120 ($110 for hypertension, diabetes, and asthma)
Specialty drugs – including biotech, biological, biopharmaceutical, and oral chemotherapy drugs.	• CVS Specialty™ Mail Order:	• CVS Specialty™ Mail Order:

Covered medications and supplies - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Covered medications and supplies (cont.)	**CDHP**	**Value Option**
All specialty drugs require prior approval. Call CVS Specialty™ at 800-237-2767 to obtain prior approval, more information, or a complete list. You may also obtain a list of specialty drugs by visiting www.nalchbp.org. Note: Some specialty medications may qualify for third party copayment assistance programs which could lower your out-of-pocket costs for those medications. When specialty medication is purchased with a third party copayment assistance coupon, rebate, or card, the Plan will not apply the amount of the discount towards your out-of-pocket maximum or deductible.	• CVS Specialty™ Mail Order: - 30-day supply: $200 - 90-day supply: $400 Note: Refer to dispensing limitations in this section.	• CVS Specialty™ Mail Order: - 30-day supply: $200 - 90-day supply: $400 Note: Refer to dispensing limitations in this section.
• Medical foods and nutritional supplements when administered by catheter or nasogastric tubes. Note: If medical foods or nutritional supplements are dispensed by a pharmacy, you will pay the appropriate pharmacy copay/coinsurance.	PPO: 20% of the Plan allowance (calendar year deductible applies) Non-PPO: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)	PPO: 20% of the Plan allowance (calendar year deductible applies) Non-PPO: 50% of the Plan allowance and the difference, if any, between our allowance and the billed amount (calendar year deductible applies)
Preventive care medications	**CDHP**	**Value Option**
Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, when prescribed by a health care professional and filled at a network pharmacy. • Over-the-counter vitamin D supplements (600-800 IU per day) for adults age 65 and older (prescription required) • Over-the-counter low-dose aspirin (75 and 81 mg) for the prevention of colorectal cancer and cardiovascular disease for adults age 50-59 as recommended by the USPSTF (prescription required) • Over-the-counter low-dose aspirin for pregnant women at high risk for preeclampsia (prescription required) • Over-the-counter vitamin supplements containing 0.4 to 0.8 mg (400 to 800 mcg) of folic acid for women planning a pregnancy or capable of becoming pregnant (prescription required) • Prescription oral fluoride supplements for children from age 6 months through 5 years	Retail: • Network retail: Nothing (No deductible)	Retail: • Network retail: Nothing (No deductible)

Preventive care medications - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Preventive care medications (cont.)	**CDHP**	**Value Option**
• FDA-approved prescription medications for tobacco cessation • Over-the-counter medications for tobacco cessation (prescription required) • FDA-approved prescription contraceptive drugs for women, including injectable drugs such as Depo provera • Medications, limited to Tamoxifen or Raloxifene for risk reduction of primary breast cancer for women who are at increased risk for breast cancer as recommended by the USPSTF • Statin preventive medications for adults at increased risk of cardiovascular disease (CVD), age 40 through 75, with a calculated 10-year CVD event risk of 10% or greater, as recommended by the USPSTF Note: The "morning after pill" is considered preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy. Note: Call us at 703-729-4677 or 888-636-NALC (6252) prior to purchasing this medication at a Network retail or mail order pharmacy.	Retail: • Network retail: Nothing (No deductible) Mail order: • 90-day supply: Nothing (No deductible)	Retail: • Network retail: Nothing (No deductible) Mail order: • 90-day supply: Nothing (No deductible)
Not covered: • *Drugs and supplies when prescribed for cosmetic purposes* • *Nutrients and food supplements, even when a physician prescribes or administers them, except as described in this Section* • *Over-the-counter medications, vitamins, minerals, and supplies, except as listed above* • *Over-the-counter tobacco cessation medications purchased without a prescription* • *Tobacco cessation medications purchased at a non-network retail pharmacy* • *Prescription oral fluoride supplements for children from age 6 months through 5 years purchased at a non-network retail pharmacy* • *Prescription oral fluoride supplements purchased at a non-network retail pharmacy* • *Prescription contraceptives for women purchased at a non-network retail pharmacy* • *Over-the-counter contraceptives purchased without a prescription* • *Prescription drugs for infertility*	*All charges*	*All charges*

Preventive care medications - continued on next page

Benefit Description	You pay After the calendar year deductible. . .	
Preventive care medications (cont.)	**CDHP**	**Value Option**
• *Over-the-counter medications or dietary supplements prescribed for weight loss* • *Prescription medications prescribed for weight loss* • *Specialty drugs for which prior approval has been denied or not obtained* • *Anti-narcolepsy and certain analgesic/opiod medications for which prior approval has been denied or not obtained* • *Certain compounding chemicals (over-the-counter (OTC) products, bulk powders, bulk chemicals, and proprietary bases)* • *Certain topical analgesics for the temporary relief of minor aches and muscle pains that may be marketed contrary to the Federal Food, Drug and Cosmetic Act (the FD&C Act)* *Note: See Section 5(h).* Wellness and Other Special Features *for information on the Enhanced CaremarkDirect Retail Program where you may obtain non-covered medications at a discounted rate.*	*All charges*	*All charges*

Section 5(g). Dental Benefits

Benefit Description	You pay
Accidental injury benefit	
No Benefit	*All charges*

Section 5(h). Wellness and Other Special Features

Special features	Description
Care support	A 24-hour nurse advisory service for your use. This program is strictly voluntary and confidential. You may call toll-free at 855-511-1893 to discuss an existing medical concern or to receive information about numerous health care and self-care issues. This also includes health coaching with a registered nurse when you want to discuss significant medical decisions. Identification and notification of potential patient safety issues (e.g., drug interactions). Individual support with a health care professional for numerous medical conditions including maternity, asthma, diabetes, congestive heart failure, healthy back and more.
Consumer choice information	Each member is provided access through www.mycigna.com or by telephone at 855-511-1893 to information which you may use to support your important health and wellness decisions, including: • Online provider directory discounted with complete national network and provider information (i.e., address, telephone, specialty, practice hours, languages spoken) • Network provider fees for comparative shopping • General cost information for surgical and diagnostic procedures and for comparison of different treatment options and out-of-pocket estimates • Provider quality information • Health calculators on medical and wellness topics
Diabetes care management program – Transform Diabetes Care	This program helps deliver better overall care and lower costs for members with diabetes. It includes a connected glucometer, unlimited test strips and lancets, medication therapy counseling from a pharmacist, two annual diabetes screenings at a CVS MinuteClinic® and a suite of digital resources through the CVS mobile App, all at no cost. Please call CVS Caremark® at 800-933-NALC (6252) for more information.
Disease management program - Gaps in Care	This program integrates medical, pharmacy, and laboratory data to identify and address members' gaps in care. Gaps in care occur when individuals do not receive or adhere to care that is consistent with medically proven guidelines for prevention or treatment. This is an outreach program for both you and your physician. Members and their physicians are informed by mail of potential gaps and are instructed on how to improve adherence to existing therapies. Some examples are: diabetes, hypertension, and cardiac disorders.
Disease management program - Your Health First	Through a clinical identification process, individuals are identified who have a chronic health condition such as asthma, COPD, depression, diabetes, or heart disease. Health advocates trained as nurses, coaches, nutritionists and clinicians use a one-on-one approach to help individuals: • Recognize worsening symptoms and know when to see a doctor • Establish questions to discuss with their doctor • Understand the importance of following doctors' orders • Develop health habits related to nutrition, sleep, exercise, weight, tobacco and stress • Prepare for a hospital admission or recover after a hospital stay • Make educated decisions about treatment options You may call 855-511-1893 to speak with a health advocate.

Enhanced CaremarkDirect Retail Program	You can purchase non-covered drugs through your local CVS network pharmacy and receive the convenience, safety, and confidentiality you already benefit from with covered prescriptions. Our Enhanced CaremarkDirect Retail is offered at no additional charge to you. Using this program at your local CVS Pharmacy, as well as all major chains, for both covered and non-covered prescriptions, will help ensure overall patient safety. The program allows you to get a discount on many prescription drugs not covered by our prescription benefit. Enhanced CaremarkDirect Retail 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 800-933-NALC (6252), 24 hours a day, 7 days a week, for a complete listing of available medications and their cost.
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8).
Health Assessment	A free Health Assessment is available at www.mycigna.com. The Health Assessment is an online program that analyzes your health related responses and gives you a personalized plan to achieve specific health goals. Your Health Assessment profile provides information to put you on a path to good physical health. If you have **Self Only** coverage with our Plan, when you complete the Health Assessment, we will enroll you in the Cigna*Plus* Savings® discount dental program and pay the Self Only Cigna*Plus* Savings® discount dental premium for the remainder of the calendar year in which you completed the Health Assessment provided you remain enrolled in our Plan. If you have **Self Plus One** or **Self and Family** coverage with our Plan, when at least two family members complete the Health Assessment, we will enroll you and your covered family members in the Cigna*Plus* Savings® discount dental program and pay the family Cigna*Plus* Savings® discount dental premium for the remainder of the year in which both Health Assessments were completed provided you remain enrolled in our Plan.

Healthy Pregnancies, Healthy Babies Program	This is a voluntary program for all expectant mothers. You will receive educational information and support throughout your entire pregnancy and after. You will speak to a pregnancy specialist and receive unlimited coaching calls to provide you with caring support to optimize your chances of having a healthy, full-term pregnancy. There will be ongoing assessments to help with early detection of a high risk pregnancy or other special needs you may have during your pregnancy. Healthy Pregnancies, Healthy Babies will work together with you and your doctor to develop a plan of care. After delivery, you will also be screened for signs of postpartum depression. Call 855-511-1893 to enroll in the Healthy Pregnancies, Healthy Babies program as soon as you know you are pregnant.
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, and healthy lifestyle products. This program promotes wellness, good health, and healthy behaviors. For more information call 855-511-1893 or visit www.mycigna.com.
Online tools and resources	Your personal, private website accessible online at www.mycigna.com • Your PCA balance and activity (also mailed quarterly) • Your complete claims payment history • A consumer health encyclopedia and interactive services • Online health risk assessment to help determine your risk for certain conditions and steps to manage them • Personal Health Record
Specialty Connect	This enhanced service combines the services of CVS Pharmacy and CVS Specialty™ by offering expanded choices and greater access to specialty medications and services. Specialty prescriptions can be submitted to any local CVS Pharmacy or to our Specialty mail pharmacies. Members will receive telephonic clinical support from our Specialty Pharmacy Care Team and will have the added option to pick up their specialty medication at a CVS Pharmacy or to have them delivered to the location of their choice. Call 800-237-2767 for more information.
Weight Management Program	The Cigna Healthy Steps to Weight Loss - Weight Management Program guides each person in creating their own tailored healthy living plan to help them eat right, participate in regular physical activity, and adopt habits that will lead to a healthy weight for life. The program is a non-diet approach to weight loss with an emphasis on changing habits. Each person seeking assistance with behavior change responds to treatment options in his or her own unique way. The program format is tailored to each individual's learning style and level of readiness to make a behavior change. Participants, with the guidance of a Wellness Coach, a trained health professional, may select the online mode or the telephone coaching model. The Wellness Coach assesses participants for their BMI, health status, motivation, self-efficacy, food choices, sleep patterns, stress level, and other relevant risk factors and co-morbidities as well as readiness to change. A toolkit is sent to each coaching program participant to assist him or her in achieving their plan goals. Individuals may register online at www.mycigna.com or by calling the toll-free number at 855-511-1893. 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*.

Non-FEHB Benefits Available to Plan Members

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

Cigna*Plus* Savings® (discount dental program)

Cigna*Plus* Savings® is a discount dental program that provides members access to discounted fees with participating dental providers. **This program is available only to members, and their dependents, of the NALC Health Benefit Plan.** The monthly Self Only premium is $3.00 and $5.00 for Self and Family. This is a discount program and not insurance, and the member must pay the entire discounted charge for dental services. For additional information or to join call 877-521-0244 or visit www.cignaplussavings.com.

Hospital Plus (hospital indemnity)

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

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

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

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

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

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

Important Notice Regarding Membership Dues

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

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

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

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

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

Section 6. General Exclusions – Services, Drugs, and Supplies We Do Not Cover

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States.
- Experimental or investigational procedures, treatments, drugs, or devices (see specific coverage for transplants in Section 5(b)).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sexual inadequacy (except gender reassignment surgeries specifically listed as covered).
- 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 yourself, 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 medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits.
- Charges which the enrollee or Plan have no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 182), doctor's charges exceeding the amount specified by the Department of Health & Human Services when benefits are payable under Medicare (limiting charge, see page 184), or State premium taxes, however applied.
- Charges for interest, completion of claim forms, missed or canceled appointments, and/or administrative fees.
- Nonmedical social services or recreational therapy.
- Testing for mental aptitude or scholastic ability.
- Therapy (other than speech, physical, occupational, and Applied Behavioral Analysis (ABA) therapy) for autism spectrum disorder.
- Transportation (other than professional ambulance services or travel under the Cigna ***Life***SOURCE Transplant Network®).
- Dental services and supplies (except those oral surgical procedures listed in Section 5(b*). Oral and maxillofacial surgery* and Section 5(g). *Dental Benefits).*
- Services for and/or related to procedures not listed as covered.
- Charges in excess of the Plan allowance.
- Treatment for cosmetic purposes and/or related expenses.
- Custodial care (see Section 10. *Definitions of Terms We Use in This Brochure*).

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

Section 7. Filing a Claim for Covered Services

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

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

How to claim benefits

High Option: To obtain claim forms, claims filing advice or answers about our benefits, contact us at 703-729-4677 or 888-636-NALC (6252) or at our website at www.nalchbp.org, or mail your claims to P.O. Box 188004, Chattanooga, TN, 37422-8004.

Consumer Driven Health Plan and Value Option: To obtain claim forms, claims filing advice or answers about our benefits, contact Cigna at 855-511-1893, or visit our website at www.nalchbp.org, or mail your claims to P.O. Box 188050, Chattanooga, TN, 37422-8050.

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

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

Note: To file a mental health and substance use disorder treatment claim, see Section 5(e). *Mental Health and Substance Use Disorder 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.

Note: A clean claim is a claim which contains all necessary information for payment including any substantiating documentation. Clean claims do not require special handling or investigation prior to adjudication. Clean claims must be filed within the timely filing period.

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, medication NDC number or name of drug or supply, prescribing physician's name, date of fill, total charge, metric quantity, days' supply, and pharmacy name and address or pharmacy NABP number.

Post-service claims procedures

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

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

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

Records

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

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

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

NALC Health Benefit Plan High Option
20547 Waverly Court
Ashburn, VA 20149

NALC CDHP or Value Option
P.O. Box 188050
Chattanooga, TN 37422-8050

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, name of pharmacy and if available, the currency used and country where purchased. 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

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

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

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

Authorized Representative

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

Notice Requirements

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

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

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

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

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

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

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

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

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

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

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

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

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

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

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

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

High Option: 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.

Consumer Driven Health Plan and Value Option: When we are the secondary payor, we limit benefits to the difference between our liability (as the primary carrier) and the primary carrier payment. When our liability is equal to, or less than, the primary carrier payment, you will receive no benefit.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

• **Medicaid**	When you have this Plan and Medicaid, we pay first. **Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.
When other Government agencies are responsible for your care	We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.
When others are responsible for injuries	**Subrogation/Reimbursement guidelines:** Our right to pursue and receive subrogation and reimbursement recoveries is a condition of and a limitation on the nature of benefits or benefit payments and on the provision of benefits under our coverage. By accepting Plan benefits, you agree to the terms of this provision. If you or your dependent have received benefits or benefit payments as a result of an injury or illness and you (or your dependent) or your representatives, heirs, administrators, successors, or assignees (or those of your dependent) receive payment from any party that may be liable or a third party's insurance policies you must reimburse us out of that payment. "Third party" means another person or entity. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise. 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 or in subrogation. You must include all benefits paid by the Plan related to the illness or injury in your claim for recovery. We are entitled to reimbursement to the extent of the benefits we have paid or provided or will pay or provide in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received. Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned or characterized (i.e., pain and suffering). Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed. You must reimburse us to the full extent we paid benefits, unless we agree to a reduction in writing. If you receive any recovery, you or your legal representative agree to hold any funds you receive in trust until you have confirmed the amount we are owed and make arrangement to reimburse us. You have the right to retain any recovery that exceeds the amount of the Plan's claim. We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights. 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. If you do pursue a claim or case related to your injury or illness (whether in court or otherwise), you must promptly notify us and cooperate with our reimbursement or subrogation efforts. You or your legal representative 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 sign our subrogation/reimbursement agreement and provide us with any other relevant information about the claim if we ask you to do so. However, a subrogation/ reimbursement agreement is not necessary to enforce the Plan's rights.

We may reduce subsequent benefit payments to you or your dependents if we are not reimbursed for the benefits we paid pursuant to this subrogation and reimbursement provision.

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

Some FEHB plans already cover some dental and vision services. Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com or by phone 877-888-3337 (TTY: 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

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

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

- Routine care costs—costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. This Plan only covers:
  - Items or services that are typically provided absent a clinical trial such as conventional care;
  - Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service such as additional charges incurred for the diagnosis or treatment of complications resulting from patient participation in a clinical trial.
- Extra care costs—costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.
- Research costs—costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800-MEDICARE (800-633-4227), TTY: 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 180.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-772-1213, TTY: 800-325-0778.

- **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 800-772-1213, TTY: 800-325-0778 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you did not take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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

Note: Please refer to page 182 for information about how we provide benefits when you are age 65 or older and do not have Medicare.

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

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

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

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

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

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

High Option: 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.

Consumer Driven Health Plan and Value Option: When Original Medicare (either Medicare Part A or Medicare Part B) is the primary payor, we will **not waive any out-of-pocket costs.**

When we are the secondary payor, we limit benefits to the difference between our liability (as the primary carrier) and the Medicare payment. When our liability is equal to, or less than, the Medicare payment, you will receive no benefit.

Note: We do not waive our deductible, copayments or coinsurance for prescription drugs or for services and supplies that Medicare does not cover. Also, we do not waive benefit limitations, such as the 12-visit limit for chiropractic services or the 50-visit limit for physical, occupational or speech therapy.

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

- **Tell us about your Medicare coverage**

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

- **Private Contract with your physician**

If you are enrolled in Medicare Part B, 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 800-MEDICARE (800-633-4227), TTY: 877-486-2048 or at www.medicare.gov.

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

  The High Option and another plan's Medicare Advantage: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even when you receive services from providers who are not in the Medicare Advantage plan's network and/or service area. However, we will not waive any of our copayments, coinsurance, or deductible. We will waive coinsurance, deductibles, and most copayments when you use a participating provider with your Medicare Advantage plan. 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.

  The Consumer Driven Health Plan and Value Option and another plan's Medicare Advantage: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even when you receive services from providers who are not in the Medicare Advantage plan's network and/or service area. When a Medicare Advantage (Part C) plan is the primary payor we will **not waive any out-of-pocket costs.**

  When we are the secondary payor, we limit benefits to the difference between our liability (as the primary carrier) and the Medicare Advantage payment. When our liability is equal to, or less than, the Medicare Advantage payment, you will receive no benefit.

  If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

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

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

  When you have Medicare Part D, we will coordinate benefits with the Medicare Prescription Drug Plan.

  High Option: When we are the secondary payor, we will pay the balance after Medicare Part D pays, up to our regular benefit.

  Consumer Driven Health Plan and Value Option: When we are the secondary payor, we limit benefits to the difference between our liability (as the primary carrier) and the Medicare Part D payment. When our liability is equal to, or less than, the Medicare Part D payment, you will receive no benefit.

  See Section 5(f). *Prescription Drug Benefits* for more information on Medicare Part D.

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

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

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

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

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

If you:

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

Then, for your inpatient hospital care:

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

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

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

If your physician:	Then you are responsible for:
Participates with Medicare or accepts Medicare assignment for the claim—whether the physician participates in our PPO network or not,	your deductibles, coinsurance, and copayments.
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.
Does not participate with Medicare and is not a member of our PPO network,	your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount.
Opts out of Medicare via private contract,	your deductibles, coinsurance, copayments, and any balance your physician charges.

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

Physicians Who Opt Out of Medicare

A physician may have opted out of Medicare, and may or may not ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by Original Medicare. This is different than a non-participating doctor, and we recommend you ask your physician if he or she has opted out of Medicare. Should you visit an opt-out physician, the physician will not be limited to 115% of the Medicare approved amount. You may be responsible for paying the difference between the billed amount and our regular in-network/out-of-network benefits.

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

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

High Option: 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.

Consumer Driven Health Plan and Value Option: We limit our payment to the difference between our liability (as the primary carrier) and the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. When our liability is equal to, or less than, the (estimated) Medicare payment, you will receive no benefit.

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.

High Option:

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

Consumer Driven Health Plan and Value Option:

When Original Medicare (either Medicare Part A or Medicare Part B) is the primary payor, we will **not waive any out-of-pocket costs**.

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

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

Section 10. Definitions of Terms We Use in This Brochure

Admission

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

Assignment

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

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See Section 4. *Your Cost for Covered Services*.

Clinical Trials Cost Categories

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

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- 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. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Congenital anomaly

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

Copayment

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

Cosmetic surgery

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

Cost-sharing

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

Covered services

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

Custodial care

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

- Caring for personal needs, such as helping the patient bathe, dress, or eat;

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

The Plan determines whether services are custodial care.

Deductible

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

Effective date

The effective date of benefits described in this brochure is:

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

Experimental or investigational service

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

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

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

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

Group health coverage

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

Health care professional

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

Medical necessity

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

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

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

Mental health and substance use disorder

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:

High Option 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 provider's network agreement. These providers accept the Plan allowance as their charge.

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

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

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

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

High Option Out-of-Network mental health and substance use disorder 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.

High Option 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);

- The Medicare rate; or
- For facility charges (such as hospitals, dialysis facilities, and ambulatory surgical centers), our allowance is based on two and one-half times the Medicare reimbursement rate.

CDHP/Value Option PPO benefits (In-Network): 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.

CDHP/Value Option Out-of-Network Benefits: Our allowance is based on two times the Medicare reimbursement 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. In the absence of seeking an expert opinion to determine Plan allowance, our allowance will be based on 80% of the billed amount.

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.

Reimbursement A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

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 determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

High Option Urgent Care Claims: If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 703-729-4677 or 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.

Consumer Driven Health Plan and Value Option Urgent Care Claims: If you believe your claim qualifies as an urgent care claim, please contact the NALC CDHP/Value Option Customer Service Department at 855-511-1893. 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 High Option, CDHP, and Value Option.

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

Section 11. Other Federal Programs

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

Important information about four Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they routinely pay for out-of-pocket.

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

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

Fourth, the **Federal Employees' Group Life Insurance Program (FEGLI)** can help protect your family from burdensome funeral costs and the unexpected loss of your income.

The Federal Flexible Spending Account Program - *FSAFEDS*

What is an FSA?

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

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,600 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to out-of-pocket dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your children under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 877-FSAFEDS (877-372-3337), TTY: 866-353-8058, Monday through Friday, 9 a.m. until 9 p.m., Eastern Time.

The Federal Employees' Dental and Vision Insurance Program - *FEDVIP*

Important information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program**. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.**

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

Beginning in 2019, FEDVIP is also available to TRICARE eligible retirees and their families during the 2018 Federal Benefits Open Season. Active duty family members are eligible to enroll in FEDVIP vision insurance. Both retirees and active duty family members must be enrolled in a TRICARE health plan in order to enroll in a FEDVIP vision plan.

Dental insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Most plans cover adult orthodontia but it may be limited. Review your plan's brochure for information on this benefit.**

Vision insurance

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

Additional information

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

How do I enroll?

You enroll online at www.BENEFEDS.com. For those without access to a computer, call 877-888-3337, TTY: 877-889-5680.

The Federal Long Term Care Insurance Program - *FLTCIP*

It's important protection

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

The Federal Employees' Group Life Insurance Program - *FEGLI*

Peace of mind for you and your family

The Federal Employees' Group Life Insurance Program (FEGLI) can help protect your family from burdensome funeral costs and the unexpected loss of your income. You can get life insurance coverage starting at one year's salary to more than six times your salary and many options in between. You can also get coverage on the lives of your spouse and unmarried dependent children under age 22. You can continue your coverage into retirement if you meet certain requirements. For more information, visit www.opm.gov/life.

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

Notes

Notes

Summary of Benefits for the NALC Health Benefit Plan High Option - 2019

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our ACA Summary of Benefits and Coverage at www.nalchbp.org. On this page we summarize specific expenses we cover; for more detail, look inside.

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

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

Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	PPO: $20 copayment per office visit Non-PPO: 30%* of our allowance	34
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	69
• Outpatient	PPO: 15%* of our allowance Non-PPO: 35%* of our allowance	71
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	76
• Medical emergency	PPO: 15%* of our allowance Non-PPO: 15%* of our allowance	76
Mental health and substance use disorder treatment:	In-Network: Regular cost-sharing Out-of-Network: Regular cost-sharing	78 78
Prescription drugs:		
• Retail pharmacy	Network: Generic: 20% of cost; 10% for hypertension, diabetes, and asthma; Formulary brand: 30% of cost; Non-formulary brand: 45% of cost	85

	Network Medicare: NALCSenior Antibiotic generic: Nothing Generic: 10% of cost; 5% for hypertension, diabetes, and asthma; Formulary brand: 20% of cost; Non-formulary brand: 30% of cost Non-network: 45% of our allowance	
• Mail order	Non-Medicare: 60-day supply, $8 generic/ $43 Formulary brand/$58 Non-formulary brand Non-Medicare: 90-day supply, $5 NALCSelect generic Non-Medicare: 90-day supply, $7.99 NALCPreferred generic Non-Medicare: 90-day supply, $12 generic/ $65 Formulary brand/$80 Non-formulary brand (Lower generic cost for hypertension, asthma, and diabetes) Medicare: 60-day supply, $4 generic/$37 Formulary brand/$52 Non-formulary brand Medicare: 90-day supply, $4 NALCSelect generic Medicare: 90-day supply, $4 NALCPreferred generic Medicare: 90-day supply, $6 generic/$55 Formulary brand/$70 Non-formulary brand (Lower generic cost for hypertension, asthma, and diabetes) 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	85
Prescription medications for tobacco cessation:		
• Retail pharmacy	Network retail, Nothing Network Medicare retail, Nothing	87
• Mail Order	Non-Medicare: 60-day supply, Nothing Non-Medicare: 90-day supply, Nothing Medicare: 60-day supply, Nothing Medicare: 90-day supply, Nothing	87
Dental care:	All charges except as listed in Section 5(g). under the *Accidental dental injury benefit.*	89
Wellness and Other Special Features:	• 24-hour help line for mental health and substance use • 24-hour nurse line • Childhood Weight Management Resource Center • Disease management programs - Gaps in Care • Disease management program - Transform Diabetes Care	90

	• Disease management program - Your Health First • Enhanced CaremarkDirect Retail Program • Flexible benefits option • Health Assessment • Healthy Pregnancies, Healthy Babies Program • Healthy Rewards Program • Personal Health Record • Services for deaf and hearing impaired • Solutions for Caregivers • Specialty Connect • Substance Use Disorder (SUD) Program • Substance Use Disorder (SUD) Care Management Program • Weight Management Program • Worldwide coverage	
Protection against catastrophic costs (out-of-pocket maximum)**:**	Services with coinsurance (including mental health and substance use disorder care), nothing after your coinsurance expenses total: • $3,500 per person and $5,000 per family for PPO providers/facilities • $7,000 for Non-PPO providers/facilities. When you use a combination of PPO and Non-PPO providers your out-of-pocket expense will not exceed $7,000. • $3,100 per person or $4,000 per family for coinsurance for prescription drugs dispensed by an NALC CareSelect network pharmacy and mail order copayment amounts. Some costs do not count toward this protection.	29

Summary of Benefits for the Consumer Driven Health Plan (CDHP) and Value Option - 2019

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions in this brochure. You can obtain a copy of our ACA Summary of Benefits and Coverage at www.nalchbp.org. On this page we summarize specific expenses we cover; for more detail, look inside.

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

Below, an asterisk (*) means the item is subject to the $2,000 calendar year deductible per person and $4,000 per family. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an Out-of-Network physician or other health care professional. You are responsible for the remaining balance after you exhaust your PCA funds.

CDHP/Value Option Benefits	You pay CDHP/Value Option	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	In-Network: 20%* of the Plan allowance Out-of-Network: 50%* of the Plan allowance and the difference, if any, between our allowance and the billed amount	116
Services provided by a hospital:		
• Inpatient	In-Network: 20%* of the Plan allowance Out-of-Network: 50%* of the Plan allowance and the difference, if any, between our allowance and the billed amount	143
• Outpatient	In-Network: 20%* of the Plan allowance Out-of-Network: 50%* of the Plan allowance and the difference, if any, between our allowance and the billed amount	145
Emergency benefits:		
• Accidental injury	In-Network: 20%* of the Plan allowance Out-of-Network: 50%* of the Plan allowance and the difference, if any, between our allowance and the billed amount	149
• Medical emergency	In-Network: 20%* of the Plan allowance Out-of-Network: 20%* of the Plan allowance and the difference, if any, between our allowance and the billed amount	149
Mental health and substance use disorder treatment:	In-Network: 20%* of the Plan allowance Out-of-Network: 50%* of the Plan allowance and the difference, if any, between our allowance and the billed amount	152

CDHP/Value Option Benefits	You pay CDHP/Value Option	Page
Prescription drugs:		
Retail	• Network retail: - Generic: $10* ($5 for hypertension, diabetes, and asthma) - Formulary brand: $40* - Non-formulary brand: $60* • Non-network retail: 50%* of the Plan allowance, and the difference, if any, between our allowance and the billed amount	158
• Mail Order	• 90-day supply: - Generic: $20* ($13 for hypertension, diabetes, and asthma) - Formulary brand: $80* ($70 for hypertension, diabetes, and asthma) - Non-formulary brand: $120* ($110 for hypertension, diabetes, and asthma)	158
Dental care:	No benefit	162
Wellness and Other Special Features	• Care support • Consumer choice information • Diabetes care management program - Transform Diabetes Care • Disease management program - Gaps in Care • Disease management program - Your Health First • Enhanced CaremarkDirect Retail Program • Flexible benefits option • Health Assessment • Healthy Pregnancies, Healthy Babies Program • Healthy Rewards Program • Online tools and resources • Specialty Connect • Weight Management Program • Worldwide coverage	163
Protection against catastrophic cost (out-of-pocket maximum):	In-Network providers/facilities, preferred network pharmacies or mail order pharmacy out-of-pocket maximum: Per person: $6,600 Per family: $13,200 Out-of-Network providers/facilities out-of-pocket maximum: Per person: $12,000 Per family: $24,000	30

2019 Rate Information for the NALC Health Benefit Plan

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare**.**

To review premium rates for all FEHB health plan options please go to www.opm.gov/FEHBpremiums or www.opm.gov/Tribalpremium.

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

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NALC, NPMHU, and NRLCA.
- If you are a career bargaining unit employee represented by the agreement with NPPN, you will find your premium rates on https://liteblue.usps.gov/fehb.
- **Postal Category 2 rates** apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

If you are a Postal Service employee and have questions or require assistance, please contact:

USPS Human Resources Shared Service Center: 877-477-3273, option 5, Federal Relay Service 800-877-8339

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
High Option Self Only	321	$230.18	$84.63	$498.72	$183.37	$81.43	$71.84
High Option Self Plus One	323	$492.27	$200.70	$1,066.59	$434.85	$193.86	$173.35
High Option Self and Family	322	$525.32	$181.61	$1,138.19	$393.49	$174.31	$152.43
CDHP Option Self Only	324	$163.91	$54.64	$355.15	$118.38	$52.45	$45.35
CDHP Option Self Plus One	326	$358.04	$119.35	$775.76	$258.59	$114.57	$99.06
CDHP Option Self and Family	325	$369.58	$123.19	$800.75	$266.92	$118.26	$102.25
Value Option Self Only	KM1	$134.53	$44.84	$291.48	$97.16	$43.05	$37.22
Value Option Self Plus One	KM3	$293.84	$97.94	$636.65	$212.21	$94.03	$81.29
Value Option Self and Family	KM2	$303.45	$101.15	$657.47	$219.16	$97.10	$83.95