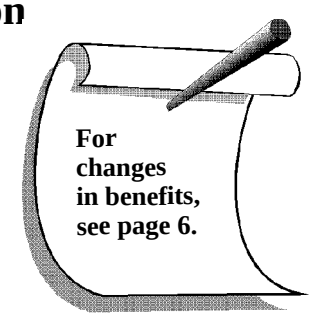
Rural Carrier Benefit Plan

http://www.NRLCA.org

2001

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



Sponsored and administered by:
The National Rural Letter Carriers' Association

Who may enroll in this Plan: Only eligible active or retired rural letter carriers of the U.S. Postal Service may enroll in this Plan. To enroll you must already be, or must become, a member of the National Rural Letter Carriers' Association.

To become a member: For information on how to become a member of the National Rural Letter Carriers' Association, please contact your State Secretary or the National Rural Letter Carriers' Association.

Membership dues: Active and retired Postal Service membership dues vary by state.

Enrollment codes for this Plan:

381 High Option - Self Only
382 High Option - Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

Federal Employees
Health Benefits Program

RI 72-005

Table of Contents

Introduction

Rural Carrier Benefit Plan
1630 Duke Street, First Floor
Alexandria, VA 22314-3466

This brochure describes the benefits of the Rural Carrier Benefit Plan under our contract (CS 1073) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means the Rural Carrier Benefit Plan.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

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

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

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

We also have Preferred Provider Organizations (PPO):

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at reduced cost. Contact us at 1-800-638-8432 or the Mutual of Omaha web site, www.mutualofomaha.com for the names of PPO providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory.

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. We have PPO networks in the following states: Alabama, Alaska, Arkansas, Washington DC, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Virginia, Washington, West Virginia, and Wisconsin. For 2001, we will add PPO networks in the following states: Arizona, California, Colorado, Connecticut, Delaware, Kansas, Maine, Massachusetts, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, Oregon, Rhode Island, South Dakota, and Utah.

How we pay providers

We generally reimburse participating providers according to an agreed-upon fee schedule and we do not offer additional financial incentives based on care provided or not provided to you. Our standard provider agreements do not contain any incentives to restrict a provider's ability to communicate with or advise you of any appropriate treatment options. In addition, we have no compensation agreement, ownership, or other influential interests that are likely to affect provider advice or treatment decisions.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. 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.

- Years in existence
- Profit Status

If you want more information about us, call 1-800/638-8432, or write to Rural Carrier Benefit Plan, 1630 Duke Street, First Floor, Alexandria, VA 22314-3466. You may also contact us by fax at 703/ 684-9627 or visit our website at www.nrlca.org

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.

- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our PPO networks will be the same with regard to deductibles, coinsurance, copayments and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing and shorter visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.

- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 1-800/638-8432, **or** checking our website www.nrlca.org You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - •• Speak up if you have questions or concerns.
  - •• Keep a list of all the medicines you take.
  - •• Make sure you get the results of any test or procedure.
  - •• Talk with your doctor and health care team about your options if you need hospital care.
  - •• Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

- North Dakota is deleted from the list of states designated as medically underserved in 2001. See page 8 for information on medically underserved areas.

Changes to this Plan

- We will add PPO networks in the following states: Arizona, California, Colorado, Connecticut, Delaware, Kansas, Maine, Massachusetts, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Dakota, Oregon, Rhode Island, South Dakota, and Utah.

- Your share of the non-postal premium will increase by 27% for Self Only and 26.7% for Self and Family for 2001.

- The copayment for prescription drugs purchased through our mail order drug program will increase from $10 to $13 for a generic drug and from $15 to $18 for a brand name drug. The copayment for retired members with Medicare Part B coverage will increase from $2 to $3 for a generic drug and from $5 to $6 for a brand name drug.

- We will provide in-network benefits for mental health and substance abuse care that are the same as for medical and surgical care. Please see Section 5(e) in this brochure for a complete description of the changes.

- The amount we pay for the Accidental Injury Benefit will be $400 for our PPO and Non-PPO benefits.

- We will eliminate the annual limit ($300) for chiropractic care. The Plan will pay chiropractic services the same as the professional services of a physician in an office setting.

- We will include a travel assistance benefit that provides you with help in getting referral for appropriate medical care and ambulance transportation when you are traveling more than 100 miles from home or in a foreign country. This service is available 24 hours a day, 7 days a week.

- We will eliminate the use of ‘credit savings” on a claim payment when coordination of benefits occurs between two or more group health plans, including Medicare. We now keep a tally of what we save as a result of coordinating benefits with another health plan that pays first. This amount is called credit savings.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card. 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 a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you 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 1-800-638-8432.

Where you get covered care

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

- **Covered providers**

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

Physician: A doctor of medicine (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), chiropractic (D.C.), and optometry (O.D.), when acting within the scope of his/her license or certification.

Qualified Clinical Psychologist: An individual who has earned either a Doctoral or Masters Clinical Degree in psychology or an allied discipline and who is licensed or certified in the state where services are performed. This presumes a licensed individual has demonstrated to the satisfaction of state licensing officials that he/she by virtue of academic and clinical experience is qualified to provide psychological services in that state.

Nurse Midwife: A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.

Nurse Practitioner/Clinical Specialist: A person who: 1) has an active R.N. license in the United States; 2) has a baccalaureate or higher degree in nursing; and 3) is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.

Clinical Social Worker: A social worker who: 1) has a master's or doctoral degree in social work; 2) has at least two years of clinical social work practice; and 3) in states requiring licensure, certification, or registration, is licensed, certified, or registered as a social worker where the services are rendered.

Nursing School Administered Clinic: A clinic that is: 1) licensed or certified in the state where the services are performed; and 2) provides ambulatory care in an outpatient setting—primarily in rural or inner-city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient 'office' services rather than facility charges.

Physician Assistant: A person who is licensed, registered, or certified in the state where services are performed.

Licensed Professional Counselor or Master's Level Counselor: A person who is licensed, registered, or certified in the state where services are performed.

For the purposes of the FEHB brochure, the term "physician" includes all of these providers when the services are performed within the scope of their license or certification.

Medically underserved areas. Note: In medically underserved areas, we cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2001, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Utah, and Wyoming.

- **Covered facilities**

Covered facilities include:

Birthing Center: A licensed facility that is equipped and operated solely to provide prenatal care, to perform uncomplicated spontaneous deliveries, and to provide immediate post-partum care.

Hospice: A public or private agency or organization that:
- Administers and provides hospice care; and
- Meets one of the following requirements:
  - Is licensed or certified as a hospice by the State in which it is located;
  - Is certified (or is qualified and could be certified) to participate as a hospice under Medicare;
  - Is accredited as a hospice by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); or
  - Meets the standards established by the National Hospice Organization.

Hospital:
- An institution that is accredited as a hospital under the hospital accreditation program of the JCAHO; or
- Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing service, and that is primarily engaged in providing:
  - General inpatient care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on it premises or under its control; or
  - Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

In no event shall the term hospital include a convalescent nursing home or institution or part thereof that:
- Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged;
- Furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or
- Is operated as a school.

Skilled Nursing Facility: An institution or that part of an institution that provides convalescent skilled nursing care 24 hours a day and is certified (or is qualified and could be certified) as a skilled nursing facility under Medicare.

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any physician 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:

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

you may be able to continue seeing your specialist 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 until the end of your postpartum care, even if it is beyond the 90 days.

Hospital care. We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800/638-8432. 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; or
- 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.

How to Get Approval for…

• Your hospital stay

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

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

Warning:

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

How to precertify an admission:

- You, your representative, your physician, or your hospital must call us at 1-800/228-0286 at least seven days before 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 Plan identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization, proposed treatment, or surgery;
  - Name and phone number of admitting doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.
- We will then tell the physician and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your physician, and the hospital.

Maternity care

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

If your hospital stay needs to be extended:

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

What happens when you do not follow the precertification rules

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and 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.
- If no one contacted us, we will decide whether the hospital stay was medically necessary.
  - If we determine that the stay was medically necessary, we will pay the inpatient charges, 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 only pay for any 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.

Exceptions: You do not need precertification in these cases:

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

• Other services Some services require a referral, precertification, or prior authorization.

- Home health care
- Hospice care
- Skilled nursing care
- Outpatient mental health and substance abuse care

Section 4. Your costs for covered services

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

• Copayments A copayment is a fixed amount of money you pay to the provider when you receive services.

Example: When you see your PPO physician you pay a copayment of $15 per visit.

• Deductible A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

•• The calendar year deductible is $250 per person under High Option. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $500 under High Option.

•• We also have separate deductibles for: hospital stays—$200 per person each calendar year; dental care—$50 per person each calendar year.

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

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

Example: You pay 25% of our allowance for office visits under our non-PPO benefit.

Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we 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 25% coinsurance, the actual charge is $75. We will pay $56.25 (75% of the actual charge of $75).

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

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

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

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance. Here is an example: 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 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 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 25% of our $100 allowance ($25). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the $50 difference between our allowance and his 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	75% of our allowance: 75
You owe: Coinsurance	15% of our allowance: 15	25% of our allowance: 25
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	$15	$75

Your out-of-pocket maximum for deductibles and coinsurance

For those benefits where coinsurance applies, we pay 100% of the Plan allowance for the rest of the calendar year after your expenses total to:

- $2,000 per person or $2,500 per family when you use PPO providers/ facilities, or

- $2,500 per person or $3,000 per family when you use PPO and non-PPO providers/facilities combined.

Your out-of-pocket maximum does not include the following:
- Copayments,
- Expenses for prescription medications you order from our mail order drug program,
- Expenses for dental care,

- Expenses in excess of our allowances or maximum benefit limits,
- Expenses for a stay in a skilled nursing facility,
- Any amount you pay for failing to get approval for a hospital stay or the continuation of a hospital stay,
- Any amount you pay for failing to get approval for outpatient mental health/substance abuse care,
- Any amount you pay for not following an approved mental health/substance abuse treatment plan, and
- Expenses you pay for services, supplies and drugs not covered by us.

When government facilities bill us

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

If we overpay you

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

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

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

If you…

- are age 65 or over, 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, or copayments you owe under this Plan;
- You are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits; and
- The law prohibits a hospital from collecting more than the Medicare equivalent amount.

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

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

If your physician…	Then you are responsible for…
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, and copayments;
Participates with Medicare and is not in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

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

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

When you have the Original Medicare Plan

We limit our payment to an amount that supplements the benefits that Medicare would pay under Part A (Hospital insurance) and Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out of pocket costs for services both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician accepts Medicare assignment, then you pay nothing for covered charges.
- If your physician does not accept Medicare assignment, then you pay the difference between our payment combined with Medicare's payment and the charge.

Note: The physician who does not accecpt 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 them to reduce their charges. If they do not, report them to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

When you have a Medicare Private Contract

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by 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 Medicare's payment.

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

Section 5. Benefits — OVERVIEW

(See page 6 for how our benefits changed this year and pages 54 and 55 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-638-8432 or at our website at www.nrlca.org

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per person ($500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In a physician's office • In an urgent care center • Office medical consultations • Routine physical exams	PPO: $15 copayment (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Second surgical opinion • At home	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG Note: We consider lab, x-ray and other diagnostic tests you receive in a physician's office during an office visit under diagnostic and treatment services above.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.

Preventive care, adult	You pay
Routine screenings, limited to: •• Sigmoidoscopy, screening - every five years starting at age 50 •• Annual coverage of one fecal occult blood test for members age 40 and older. •• Prostate Specific Antigen (PSA test) - one annually for men age 40 and older. •• Routine pap test Note: The office visit is covered if pap test is received on the same day; see Diagnostic and treatment services on page 16. •• Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics for dependent children under age 22. Note: Associated charges for office visits and other services will be considered under Diagnostic and treatment services on page 16.	PPO: Nothing (No deductible) Non-PPO: Nothing up to Plan allowance then any difference between our allowance and the billed amount (No deductible)
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits, Section 5(c) and Surgery benefits, Section 5(b).	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Note: If your child is not covered under a Self and Family enrollment, you pay all of your child's charges after your discharge from the hospital.

Maternity care — Continued on next page

Maternity care — *Continued*	**You pay**
Not covered: • *Procedures, services, drugs, and 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 and supplies related to treatment of impotency.*	*All charges.*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) Note: We cover contraceptive drugs in Section 5(f).	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges.*
Infertility services	
Note: The Plan will pay up to $5,000 per person per lifetime for covered infertility services, including prescription drugs.	PPO: 15% of the Plan allowance up to $5000 then all charges Non-PPO: 25% of the Plan allowance up to $5000 and any difference between our allowance and the billed amount then all charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *artificial insemination* •• *in vitro fertilization* •• *embryo transfer and GIFT* •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures.*	*All charges.*
Allergy care	
Testing and treatment, including materials (such as allergy serum)	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Allergy injection	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 25. • Dialysis — Hemodialysis and peritoneal dialysis Note: The Plan pays for services, supplies, and testing for kidney (renal) dialysis under Special Features, Section 5(g). • Intravenous (IV)/Infusion Therapy — Home IV and antibiotic therapy • Respiratory and inhalation therapies	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Rehabilitative therapies	
Physical therapy, occupational therapy, and speech therapy - • 90 visits per calendar year for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury and when a physician: 1) orders the care; 2) identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 3) indicates the length of time the services are needed.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	
Testing only when necessitated by accidental injury or illness	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Hearing testing* • *Hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: See Special Features, Section 5(g), for our benefit for routine eye examinations.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

Vision services (testing, treatment, and supplies) — Continued on next page

Vision services (testing, treatment, and supplies) — *Continued*	**You pay**
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*
Foot care	
No Benefit	All charges.
Not covered: • *Treatment or removal of corns and calluses, or trimming of toenails* • *Orthopedic shoes, orthotics, and other devices to support the feet*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Corsets, trusses, elastic stockings and other supportive devices*	*All charges.*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1) Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2) Are medically necessary; 3) Are primarily and customarily used only for a medical purpose; 4) Are generally useful only to a person with an illness or injury; 5) Are designed for prolonged use; and 6) Serve a specific therapeutic purpose in the treatment of an illness or injury. Also included are: • Take-home items from the hospital; and • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME) — Continued on next page

Durable medical equipment (DME) — *Continued*	**You pay**
We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Wheelchairs; • Crutches; and • Walkers. Note: Call us at 1-800/638-8432 as soon as your physician prescribes this equipment.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Home health services	
If home health services are precertified, 90 days per calendar year up to a maximum plan payment of $80 per day 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: (No deductible); all charges after we pay $80 per day Non-PPO: (No deductible); all charges after we pay $80 per day
If home health services are not precertified, 40 days per calendar year up to a maximum plan payment of $40 per day.	PPO: (No deductible); all charges after we pay $40 per day Non-PPO: (No deductible); all charges after we pay $40 per day
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication*	*All charges.*
Alternative treatments	
Chiropractic care	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Acupuncture* • *Naturopathic services* Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 8.	*All charges.*

Educational classes and programs	You pay
Coverage is limited to: • Smoking Cessation - Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. Note: Smoking cessation drugs and medications are not available under any other Plan provisions.	PPO: Any charges in excess of $100 (No deductible). Non-PPO: Any charges in excess of $100 (No deductible).

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per person ($500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "No deductible" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION OF INPATIENT SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**

IMPORTANT

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.	
Surgical procedures	
• Operative procedures, including delivery of a newborn and circumcision • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedure • Biopsy procedure	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Surgical procedures — Continued on next page

Surgical procedures — *Continued*	**You pay**
• Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See Section 5(a) — Orthopedic braces and prosthetic devices for device coverage information • Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons — we cover up to 20% of our allowance for the primary surgeon's charge	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: •• PPO 90% of the Plan allowance or •• Non-PPO: 85% of the reasonable and customary charge • For the secondary procedure(s): •• PPO: 90% of one-half of the Plan allowance or •• Non-PPO: 85% of one-half of the reasonable and customary charge Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s). (No deductible) Non-PPO: 15% of the Plan allowance for the primary procedure and 15% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount. (No deductible)
Not covered: • *Treatment or removal of corns and calluses, or trimming of toenails.* • *Radial keratotomy or similar surgery done in treating myopia (except for cornea graft).* • *Dental appliances, study models, splints, and other devices or service related to the treatment of TMJ dysfunction.* • *Reversal of voluntary, surgical sterilization.*	*All charges.*

Reconstructive surgery	You pay
• 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 condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses; and surgical bras and replacements (see Prosthetic devices in Section 5(a) for coverage) 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: 10% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
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 and reconstruction of a breast following* mastectomy • *Surgeries related to sex transformation or sexual dysfunction*	*All charges.*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of pathological tori, tumors, and premalignant and malignant lesions • Excision of cysts and incision of abscesses when done as independent procedures • Surgical correction of temporomandibular joint (TMJ) dysfunction • Dental surgical biopsy • Extraction of impacted (unerupted) teeth • Frenectomy and frenotomy not as a result of orthodontic care	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Oral and maxillofacial surgery — Continued on next page

Oral and maxillofacial surgery — *Continued*	**You pay**
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.*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung and double lung. • Pancreas (when condition is not treatable by insulin use) Bone marrow transplants and stem cell support for: • Allogeneic bone marrow transplants • Autologous bone marrow transplants (autologous stem cell support) Autologous peripheral stem cell support for: • Acute lymphocytic or non-lymphocytic leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Advanced neuroblastoma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Epithelial ovarian cancer • Breast cancer • Multiple myeloma Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	PPO: 10% of the Plan allowance (No deductible). Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible). Note: Mutual of Omaha has special arrangements with 15 facilities to provide services for tissue and organ transplants—its Medical Specialty Network. The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. For a list of facilities included in the Medical Specialty Network, call Customer Service at 1-800/638-8432, consult a provider directory, or visit Mutual of Omaha's website at www.mutualofomaha.com
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered above*	*All charges.*

Anesthesia	You pay
Professional services provided in: • Hospital (inpatient)	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Professional services provided in: • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	PPO: 15% of the Plan allowance (no deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Unlike Sections (a) and (b), in this section the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)".
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
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; • general nursing care; and • meals and special diets.	PPO: Nothing Non-PPO: $200 deductible per calendar year then nothing

Inpatient hospital — Continued on next page

Inpatient hospital — *Continued*	**You pay**
NOTE: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, 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 prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	NOTE: If you use a PPO provider and a PPO facility, we may still pay non-PPO benefits if you receive treatment from a radiologist, pathologist, or anesthesiologist who is not a PPO provider.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen NOTE: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.	PPO: Nothing Non-PPO: 20% of charges
Not covered: • *Any part of a hospital admission that is not a medical necessity (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: 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 definition) even when in a hospital* • *Non-covered facilities, such as nursing homes, rest homes, convalescent homes, facilities for the aged, extended care facilities, and schools* • *Personal comfort items, such as telephone, television, radio, newspapers, air conditioner, beauty and barber services, guest meals and beds* • *Private nursing care during a hospital stay*	*All charges.*

Outpatient hospital surgery or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines (not take home drugs) • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, casts, and sterile tray services • Medical supplies, including oxygen NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We may cover the dental procedure (see pages 38 and 39). NOTE: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the physician bills for surgery, we pay Surgery benefits.	PPO: Nothing (No deductible). Non-PPO: Nothing (No deductible) up to our allowance, then all charges.
Extended care benefits/Skilled nursing care facility benefits	
Skilled nursing facility (SNF): If the stay is precertified, we pay 100% of the reasonable and customary charges for a maximum of 60 days in a calendar year.	PPO: Nothing for the first 60 days then all charges Non-PPO: Nothing for the first 60 days then all charges
If the stay is not precertified, we pay 80% of the reasonable and customary charges for a maximum of 30 days in a calendar year, when the services are medically necessary.	PPO: 20% for the first 30 days then all charges Non-PPO: 20% for the first 30 days, then all charges.
Not covered: • *Custodial care*	*All charges.*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill prescribed by a physician and provided by a medically supervised team under the direction of a Plan-approved independent hospice administration.	
• We pay up to $7,500 per lifetime for inpatient and outpatient services, if the care is precertified. • We pay up to $5,500 per lifetime for inpatient and outpatient services, if the care is not precertified.	Nothing up to $7,500, if care is precertified. Then all charges over $7,500. Nothing up to $5,500, if care is not precertified. Then all charges over $5,500.
Not covered: • *Independent nursing* • *Homemaker services*	*All charges.*
Ambulance	
• Local professional ambulance service when medically appropriate	PPO: 15% of Plan allowance (Calendar year deductible applies) Non-PPO: 25% of Plan allowance and any difference between our allowance and the billed amount (Calendar year deductible applies)
Not covered: • *Ambulance transportation from the hospital to home*	*All charges.*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible is: $250 per person ($500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings.

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 or a family member is accidentally injured, the Plan will pay 100% of reasonable and customary charges up to the maximum benefit for: • Physician services and supplies • Related outpatient hospital services Note: To be eligible for benefits under this provision, initial and follow-up care must be received within five days of the injury. Note: We pay Hospital benefits if you are admitted. See page 38 for accidental dental injuries.	PPO: Nothing (No deductible) The Plan will pay up to $400. Non-PPO: Nothing (No deductible). The Plan will pay up to $400
If you receive care for your accidental injury after 5 days, we cover: • Non-surgical physician services and supplies Note: We pay Hospital benefits if you are admitted.	PPO: 15% of Plan allowance Non-PPO: 25% of Plan allowance and any difference between our allowance and the billed amount
Ambulance	
Professional ambulance service Note: See Section 5(c) for non-emergency service.	PPO: 15% of Plan allowance Non-PPO: 25% of Plan allowance and any difference between our allowance and the billed amount

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

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

You may now choose to get care Out-of-Network (non-PPO) the same as before or **In-Network** (PPO) that is new for 2001. When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible or, for facility care, the inpatient deductible apply to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network (non-PPO) benefits begin on page 32.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
In-Network benefits	
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. We will reduce your benefits if you do not precertify, preauthorize, get review of continuing treatment, or follow our approved treatment plan for all levels of care.	Your cost sharing responsibilites are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	15% of Plan allowance (No deductible for outpatient physician visits)
• Diagnostic tests	15% of Plan allowance
• Services provided by a hospital or other facility	Nothing (No deductible)

• Services in approved alternative care settings such as:
  • Partial hospitalization includes a time-limited, ambulatory, active treatment program that:
  • Offers intensive clinical services that are coordinated and structured in stable surroundings; and
	15% of Plan allowance

In-Network benefits — Continued on next page

In-Network benefits — *Continued*	**You pay**
• Provides at least 20 hours of scheduled programs in a licensed or accredited facility over at least five days per week • Intensive outpatient programs offer time-limited programs that: • Are coordinated, structured and intensively therapeutic; • Are designed to treat a variety of people with moderate to severe problems with at least one area of daily life because of a mental health or substance abuse condition; and • Provide 3-4 hours of active treatment each day for at least 2-3 days a week	15% of Plan allowance
Not covered: • *Services we have not approved.* • *Counseling or therapy for marital, educational, sexual, or behavioral problems* • *Treatment of mental retardation and learning disabilities* *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.*

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our authorization processes. These include:

- Precertification to establish the medical necessity of your stay in a hospital or other facility. Please see page 10 for information on how to precertify your care. If you do not precertify your stay, we will reduce our benefits by $500.
- Preauthorization to establish the medical necessity for all levels of outpatient or office care by your physician or other covered provider. Please see page 10 for information on how to preauthorize your care. If you do not preauthorize your care within two business days of the first visit, we will reduce our benefits by 50%.
- Review of continuing treatment to establish the medical necessity of your continuing treatment for all levels of outpatient or office care. Please see page 10, for information on how to get review of continuing treatment. If you do not get your continuing treatment reviewed or you do not follow your treatment plan, we will reduce our benefits by 50%.

Network deductibles and out-of-pocket maximums

A $250 calendar year deductible applies to outpatient charges and inpatient and outpatient professional charges. We waive the calendar year deductible for office visits with PPO physicians. Once you reach the combined out-of-pocket maximum (see page 12), the Plan will pay 100% of its allowance for the rest of the calendar year.

Network limitation

If you do not obtain and follow an approved treatment plan, we will provide only out-of-network benefits.

How to submit Network claims

Follow the normal claim procedure on page 42.

Out-of-Network benefit

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- See page 30 for In-Network (PPO) benefits.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.

Out-of-Network inpatient mental health benefits	You pay
We pay 100% of room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets.	$200 deductible per calendar year then nothing
We pay 80% of other hospital services and supplies, such as: • Prescribed drugs and medicines • Diagnostic laboratory tests • Medical supplies and equipment	20% of charges
Services in Alternative Care Settings	

• Partial hospitalization includes a time-limited, ambulatory, active treatment program that:
  • Offers intensive clinical services that are coordinated and structured in stable surroundings; and
  • Provides at least 20 hours of scheduled programs in a licensed or accredited facility over at least five days per week
• Intensive outpatient programs offer time-limited programs that:
  • Are coordinated, structured and intensively therapeutic;
  • Are designed to treat a variety of people with moderate to severe problems with at least one area of daily life because of a mental health or substance abuse condition; and
  • Provide 3-4 hours of active treatment each day for at least 2-3 days a week.
	25% of Plan allowance and any difference between our allowance and the billed amount

Inpatient/Outpatient Treatment Sessions	
We pay for psychiatric treatment sessions (including group sessions) up to a maximum of $75 per session. This benefit also applies to treatment sessions billed by a hospital or provided by the hospital staff.	All charges in excess of $75 (No deductible)

Out-of-Network substance abuse benefits	You pay
We will pay up to a maximum of $5,500 for inpatient treatment in an accredited facility or for an outpatient treatment program. NOTE: This benefit is limited to two inpatient treatment programs per person per lifetime	Nothing up to $5,500, then all charges
Not covered out-of-network: • *All charges (including room and board) for chemical aversion therapy, conditioned reflex treatments, narcotherapy, and similar aversion treatments* • *Biofeedback and milieu therapy* • *Counseling or therapy for educational or behavioral problems* • *Counseling or therapy for mental retardation or a learning disability* • *Counseling services for marital or family problems*	*All charges.*

Precertification	Follow the normal procedure on page 10 to get approval for your hospital stay, partial hospitalization, or intensive outpatient program.
Out-of-Network out-of-pocket maximum	For those benefits where coinsurance applies, we pay 100% of the Plan allowance for the rest of the calendar year after your expenses (including the deductible) total to $8,000 per person during a calendar year
How to submit Out-of-Network claims	Follow the normal claim procedure on page 42.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per person ($500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "No deductible" to show when the calendar year deductible does not apply
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain your prescription.** You may fill your prescription at a Caremark network pharmacy, a non-network pharmacy, or through the Caremark mail order prescription program.

  •• **Caremark network pharmacy**

  You may fill your prescription at a Caremark network pharmacy. To find a participating pharmacy where you live, call Caremark toll-free at 1-800/831-4440 or on the Internet at www.rxrequest.com or as a link through our web page at www.nrlca.org. **You must show the pharmacy your Plan ID card (that includes the Caremark logo) or a Caremark prescription drug card to receive the negotiated discount price.** You pay the full discounted price for your prescription and then file a claim with us. **Prescriptions you purchase at a Caremark network pharmacy without using your ID card or a Caremark drug card are at the full regular price charged by the pharmacy.**

  •• **Non-Network Pharmacy**

  You may fill your prescription at any non-network pharmacy. You pay the full regular price for your prescription and then file a claim with us.

  •• **Caremark mail order prescription program**

  You may fill your long-term prescription through the Caremark mail order prescription program. You will receive order forms and information on how to use the mail order prescription program with your Plan ID card. To order your prescription by mail: 1) complete the Caremark order form; 2) enclose your prescription(s) and copayment(s); (3) mail your order to Caremark, PO Box 659572, San Antonio, TX 78256-9577; and 4) allow approximately two weeks for delivery. You will receive order forms for refills and future prescription orders each time you use the mail order program. You can also order refills from the mail order program by telephone toll-free at 1-800/344-8075 or on the Internet at www.rxrequest.com.

- **These are the dispensing limitations.**
  - •• You may purchase up to a 34-day supply of medication at a Caremark network pharmacy. There is no limit on the number of refills that you can buy at a Caremark network pharmacy.
  - •• There is no day supply or refill limit for medications that you buy at a non-network pharmacy.

•• You may purchase up to a 90-day supply of a medication through the Caremark mail order prescription program. If you request a refill before you use 75% of the medication (based on your physician's written directions for taking the medication), Caremark will return the refill request to you. Caremark follows generally accepted pharmacy standards when filling your prescriptions. These include Federal and state pharmacy regulations, the professional judgment of the pharmacist, and the usage recommendations of the drug manufacturer as approved by the U.S. Food and Drug Administration (FDA). If a Federally approved generic drug is available, Caremark will substitute for a brand name drug unless your physician specifies that it is medically necessary that you receive the brand name drug. Certain types of prescription medications are not available through the mail order program such as:

- Specially mixed (compounded) capsules and supporitories
- Vaccines
- Frozen medications
- Dental products
- Most medical devices
- Smoking cessation drugs
- Infertility drugs

Caremark will fill prescriptions for medications designated as Class II, III, IV, and V controlled substances by the FDA. However, Federal or state law may limit the supply of these medications to less than 90 days.

- When you have to file a claim. Follow the normal claim procedure on page 42. There is no special claim form to fill out for your prescription drug expenses.

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.	
Covered medications and supplies	
When you enroll in the Plan, you will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a pre-addressed reply envelope for the mail-order prescription program. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs and medicines (including those prescribed during a non-covered hospital stay or in a non-covered facility) that require a physician's prescription by Federal law of the United States except as shown below • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices	• Network Retail: 25% of cost • Network Retail with Medicare Part B: 25% of cost • Non-Network Retail: 25% of cost • Non-Network Retail with Medicare Part B: 25% of cost • Network Mail Order: $13 generic/$18 brand name (no deductible) • Network Mail Order with Medicare Part B: $3 generic/$6 brand name (No deductible) Note: If there is no generic equivalent drug available, you will still have to pay the brand name copayment.

Covered medications and supplies — Continued on next page

Covered medications and supplies — *Continued*	**You pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name. • If you have Medicare Part B, we do not waive your deductible or coinsurance for prescription drugs and supplies that you buy at a Caremark network pharmacy or at a non-network pharmacy. However, your copayment is reduced for prescriptions that you order through the Caremark mail order prescription program. • We have an open formulary for our mail order prescription program. If your physician believes a brand name drug is necessary or there is no generic available, your physician may prescribe a brand name drug from a formulary list. This list of brand name drugs is a preferred (not required) list of drugs that we selected to meet patient needs. To request a prescription drug formulary list, call Caremark toll-free at 1-800/831-4440.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to treat impotence and sexual dysfunction* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription (over-the-counter) medicines*	*All charges.*

Section 5 (g). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call Optum NurseLine toll-free at 1-877/610-9822 and talk with a registered nurse who will discuss treatment options and answer your health questions and concerns. This service is also available on the Internet at www.healthforums.com.
Services for deaf and hearing impaired	No benefit
Cancer treatment benefit	We will pay 100% of the Plan allowance for services and supplies normally covered by the Plan for treatment of an illness diagnosed as cancer. The service or supply must be for the treatment of a malignancy. A diagnosis secondary to cancer is not covered under this benefit.
Kidney (renal) dialysis benefit	We will pay 100% of the Plan allowance for services, supplies and testing for kidney (renal) dialysis. This benefit applies to inpatient and outpatient kidney dialysis.
Routine eye exam benefit	We will pay up to $45 per person for one routine eye exam each calendar year. Note: The itemized bill must show that you had a routine eye exam to qualify for this benefit.
Reciprocity benefit	No benefit
High risk pregnancies	No benefit
Centers of excellence for transplants/heart surgery/etc	Mutual of Omaha has special arrangements with 15 medical facilities to provide services for tissue and organ transplants—its Medical Specialty Network. The network is designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. For a list of facilities included in the Medical Specialty Network, call Customer Service at 1-800/638-8432, consult a PPO directory, or visit Mutual of Omaha's website at www.mutualofomaha.com
Travel benefit/ services overseas	In case of a medical problem while traveling in a foreign country or more than 100 miles from home, you can call toll-free 1-877/715-2596 for a referral to an English-speaking physician, clinic or hospital. This service is available 24 hours a day, 7 days a week anywhere in the world.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The dental deductible is: $50 per person. The dental deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage.
- Note: We cover a hospital stay for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We cover the dental procedure under Dental benefits listed below.

IMPORTANT

Accidental dental injury benefit	You pay
We will pay 100% of reasonable and customary charges for the treatment or repair (including root canal therapy and crowns) of an accidental injury (not from biting or chewing) to sound, natural teeth. The accident must occur while you are covered by an FEHB plan, and the treatment or repair must be performed within one year of the accident. If treatment or repair to a child's teeth requires a delay because of the child's age, we may extend coverage for no more than three years from the date of the accident. The request for the delay in treatment must be made to us within one year of the accident, and the child must remain covered by the Plan until treatment is completed. Note: We may request dental records, including x-rays, to verify the condition of your teeth before the accidental injury. Charges covered for dental accidents cannot be considered under Dental Benefits.	Nothing up to our allowance then all charges.

Dental benefits

Service	We pay (scheduled allowance)	You pay
Preventive Care—We cover up to two visits per person during the calendar year (No deductible).		All charges in excess of the scheduled amounts listed to the left
Oral exam	$ 12.50	
Prophylaxis, adult	$ 22.00	
Prophylaxis, child (thru age 14)	$ 15.00	
• with fluoride treatment	$ 24.00	
Space maintainer	$ 88.00	
Complete X-ray series	$ 34.00	
Panoramic X-ray	$ 34.00	
Single film X-ray	$ 5.50	
Each additional X-ray film (up to 7)	$ 4.00	
Bitewings - 2 films	$ 9.00	
Bitewings - 4 films	$ 14.00	

Dental benefits — Continued on next page

Dental benefits — *Continued*

Service	We pay (scheduled allowance)	You pay
Restorative Care—After a deductible of $50 per person during the calendar year, we cover the following services. There is no annual dollar limit for these services.		All charges in excess of the scheduled amounts listed to the left
Restorations		
Amalgam - 1 surface deciduous	$ 12.50	
Amalgam - 2 surfaces deciduous	$ 18.50	
Amalgam - 3 or more surfaces deciduous	$ 23.50	
Amalgam - 1 surface permanent	$ 14.00	
Amalgam - 2 surfaces permanent	$ 20.50	
Amalgam - 3 or more surface permanent	$ 26.50	
Silicate cement	$ 13.50	
Acrylic or plastic	$ 21.50	
Gold	$103.50	
Extractions (uncomplicated)		
Single tooth	$ 16.00	
Each additional tooth	$ 15.00	
Pulp capping - direct	$ 9.50	
Pulpotomy - vital	$ 21.00	
Pontics		
Porcelain fused to gold	$120.00	
Dowel pin	$ 25.00	
Root canal therapy		
One root	$106.00	
Two roots	$126.00	
Three or more roots	$170.00	
Gingival curettage (per quadrant)	$ 26.50	
Crowns		
Plastic with gold	$120.00	
Porcelain	$113.50	
Porcelain with gold	$120.00	
Gold (full cast)	$120.00	
Gold (3/4 cast)	$120.00	
Stainless steel	$ 21.50	
Dentures		
Complete upper or lower	$126.00	
Partial without bar	$138.00	
Partial with bar	$157.00	
Repairs	$ 14.00	
Relining	$ 40.50	

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

The benefits 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 deductibles or out-of-pocket maximums.

Long term care insurance—Long term care is open to NRLCA members, their spouse, parents and parents-in-law under age 80. Premium rates are based on your age at the time of approval for coverage. Please consult the separate descriptive pamphlet for detailed information.

- Covers skilled nursing, intermediate nursing and custodial care in a nursing home, skilled nursing facility, or assisted living home; $100 per day benefit
- Covers outpatient care for home health care, adult day care and respite care; $50 per day benefit
- Includes return of premium feature
- Includes inflation protection option

Long term disability income insurance—The Rural Letter Carrier Long Term Disability (RLCLTD) Income Plan protects an individual from being unable to work and earn a paycheck because of an illness or injury. The RLCLTD Plan is available to active regular rural letter carriers that are members of the NRLCA. Premium rates are based on your age and benefit level selected. Please consult the separate descriptive pamphlet for detailed information.

- Two benefit levels with a waiting period
- Replacement of 50% or 60% of your basic pay tax-free
- Benefits payable to age 65
- Premiums payable through payroll allotment

Supplemental dental insurance—The NRLCA Dental Plan is available to all NRLCA members. The Plan features a schedule of benefits for a variety of dental care services. Premium rates are based on geographic regions across the country and are guaranteed for three years from the time of initial enrollment in the Plan. The Plan allows members to use any licensed dentist with improved benefits if you use one of more than 45,000 preferred dental offices throughout the country. Benefits include:

- Diagnostic and Preventive Care
- Oral Surgery
- Restorative Care
- Endodontic Care (Root Canals)
- Periodontic Care (Gum Disease)
- Prosthodontic Care (Crowns and Dentures)

Please consult the separate descriptive pamphlet for detailed information.

Term life insurance—The NRLCA Life Insurance Plan is available to actively employed members of the NRLCA under age 60. Premium rates are based on your age at time of approval for coverage and at each renewal date. Please consult the separate descriptive pamphlet for detailed information.

- Provides up to $200,000 of term life insurance coverage in $25,000 multiples
- Provides up to $40,000 accidental death and dismemberment coverage
- Family life insurance coverage up to $10,000
- Living Care benefit for terminally ill enrollees

For further information on any of the above benefits, contact the NRLCA Insurance Department at:

NRLCA Group Insurance Department
1630 Duke Street**,** First Floor
Alexandria, VA 22314-3466
1-703/684-5552

Benefits on this page are not part of the FEHB contract

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

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction or impotence;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs or supplies when no charge would be made if you had no health insurance coverage;
- Services, drugs, or supplies you receive without charge while in active military service; or required for illness or injury you sustain on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions; or (2) during combat;
- Services, drugs, or supplies you receive from immediate relatives or household members, such as spouse, parents, child, brother or sister by blood, marriage, or adoption;
- Services or supplies you receive at a facility not covered under the Plan, except that medically necessary prescription drugs are covered;
- Charges for services and supplies that are not reasonable and customary;
- Any part of a provider's fee or charge that you would ordinarily pay but is waived by the provider. If a provider routinely waives (does not require you to pay) a deductible or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges that you or us has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Part A and/or B (see page 13), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) or State premium taxes however applied;
- Custodial care;
- Acupuncture;
- Preventive medical care and services, except those provided under Preventive care adult and Preventive care children in Section 5(a);
- Weight control or any treatment of obesity except surgery for morbid obesity (ileojejunal, balloon or gastric shunt procedures);
- Programs for smoking cessation and related drugs even if prescribed by a physician, except as provided in Section 5(a);
- Private duty nursing care that you receive during a hospital stay
- Any services you receive related to a learning disability;
- Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning;
- Breast implants (except after mastectomy), injections of silicone or other substances, and all related charges;
- Nonmedical services such as social services and recreational, educational, visual, and speech therapy (except as provided for in Section 5(a));
- Hearing aids and examinations for them;
- Eyeglasses and contact lenses (except as covered in Section 5(a));
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices; or
- Services, drugs and supplies for cosmetic purposes

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 1-800/638-8432.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800/638-8432.

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

- Name of patient and relationship to enrollee;
- Plan identification number of the enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

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

In addition:

- You must send a copy of the explanation of benefits (EOB) from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not ordered through the Mail Order Prescription Drug Program must include receipts that have the patient's name, the prescription number, name of drug or supply, prescribing physician's name, date, charge and pharmacy name. The pharmacist must sign any computer printout or pharmacy ledger.

Records

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim no more than two years after you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

Follow the same procedures when submitting claims for overseas (foreign) services as you would when submitting claims for stateside services. Claims for overseas services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred. We will provide translation and currency conversion services for claims for overseas (foreign) services.

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
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: Rural Carrier Benefit Plan, P.O. Box 668329, Charlotte, NC 28266-8432; 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.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial — go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it.
	You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, D.C. 20044-0436.
	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.

	Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
5	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct based on the terms of the contract. OPM will send you a final decision within 60 days. There are no other administrative appeals.
6	If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.
	You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-638-8432 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division II at 202/606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

• What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

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

• The Original Medicare Plan

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care, except you do not need to get a hospital stay approved when Medicare pays first.

Claims process — You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800/638-8432.

We waive some costs when you have Medicare — When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive our $250 calendar year deductible and pay the $100 Part B deductible for you.

NOTE: We do not waive the $250 calendar year deductible for prescription drug expenses when the medication is purchased at a pharmacy.

- Services and supplies provided in a hospital or other covered facility. If you are enrolled in Medicare Part A, we will waive our $200 hospital deductible and pay the Part A deductible for you.

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

Primary Payer Chart

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

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in a Medicare managed care plan. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles.

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

- **Private Contract**

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

- **Enrollment in Medicare Part B**

Note: We cannot require you to enroll in Medicare. If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program.

TRICARE

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms used in this brochure

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.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 11.

Covered services

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

Custodial care

Treatment or services, no matter who recommends them or where you receive them, which a person without medical skills can provide safely and reasonably. In addition, treatment and services designed mainly to help the patient with daily living activities. These include:

- personal care like help in: walking; getting in and out of bed; bathing; eating (by spoon, gastrostomy or tube); exercising; dressing
- homemaking services, like preparing meals or special diets
- moving the patient
- acting as a companion or sitter
- supervising the taking of medication that can usually be self-administered; or
- treatment or services that anyone can perform with minimal training like recording temperature, pulse and respirations or administering and monitoring a feeding system.

We determine what treatments or 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 page 11.

Experimental/ investigational services

A drug, device or biological product is experimental or investigational if the drug, device or biological product cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished to you. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device biological product is experimental or investigational if:

- reliable evidence shows that it is the subject of on-going phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
- reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

Medical necessity

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

- are appropriate to diagnose or treat the patient's 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 the patient, the family, or the provider;
- are not a part of or associated with the scholastic education or vocational training of the patient; and
- in the case of inpatient care, cannot be provided safely in an outpatient setting.

The fact that a covered provider prescribes, recommends, or approves a service, supply**,** drug or equipment does not, by itself, make it a medical necessity.

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:

We base our Plan allowance on reasonable and customary charges. Reasonable and customary charges are those charges that are comparable to charges made by other providers for similar services and supplies under comparable circumstances in the same geographic area. We develop the Plan's allowances from actual claims received in each zip code throughout the United States, as complied by the Health Insurance Association of America. We review and update the allowances twice a year (January 1 and July 1), using the 90th percentile for all charges for a medical procedure. Preferred providers accept the plan allowance as payment in full. For certain services, exceptions may exist to this general method for determining the Plan's allowance.

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

Us/We

Us and we refer to the Rural Carrier Benefit Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

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

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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.

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

- **Spouse equity coverage**

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

- **TCC**

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

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

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

- **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800/638-8432 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

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

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for the Rural Carrier Benefit Plan — 2001

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $250 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:	**PPO:** $15/office visit	
• Diagnostic and treatment services provided in the office	**Non-PPO:** 25% of our allowance and any difference between our allowance and the billed amount*	16
• Surgery	**PPO:** 10% of our allowance	22-25
	Non-PPO: 15% of our allowance and any difference between our allowance and the billed amount	
Services provided by a hospital:		
• Inpatient	**PPO:** Nothing	26-27
	Non-PPO: $200 deductible per calendar year; nothing for room and board; 20% of other charges	
• Outpatient	**PPO:** 15% of our allowance*; nothing for a surgical facility	28
	Non-PPO: 25% of our allowance and any difference between our allowance and the billed amount*, any difference between our allowance and the billed amount for a surgical facility	
Emergency benefits:		
• Accidental injury	Up to $400	29
• Medical emergency	Regular benefits	16-28
Mental health and substance abuse treatment	**PPO:** Nothing	30
• Inpatient	**Non-PPO:** $200 deductible per calendar year; nothing for room and board; 20% of other charges. For substance abuse, charges over $5,500 per treatment program	32
• Outpatient	**PPO:** 15% of Plan allowance* (no deductible on physician visits)	30-31
	Non-PPO: Charges over $75 per treatment session (no deductible). For substance abuse, charges over $5,500 for an aftercare program (combined with inpatient)	32-33

Summary or benefits — Continued on next page

Benefits	You Pay	Page
Prescription drugs	**Network and non-network pharmacy:** 25% of the cost* **Mail Order Pharmacy:** $13/generic drug; $18/brand name drug **With Medicare Part B:** $3/generic drug; $6/brand name drug	34-36
Dental Care	Any difference between our scheduled allowance and the billed amount	38-39
Special features: Flexible benefits option; Cancer treatment benefit; Kidney dialysis benefit; 24 hour nurse line, Travel assistance program; Routine eye exam benefit		37
Protection against catastrophic costs ..... (your out-of-pocket maximum)	**PPO:** Nothing after $2,000/Person or $2,500/Family per year **Non-PPO:** Nothing after $2,500/Person or $3,000/Family per year Note: Benefit maximums apply and some costs do not count toward this protection	12-13

2001 Rate Information for

Rural Carrier Benefit Plan

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Nationwide							
High Option Self Only	381	N/A	N/A	$187.61	$110.09	$102.22	$35.18
High Option Self and Family	382	N/A	N/A	$424.28	$182.11	$231.17	$48.70