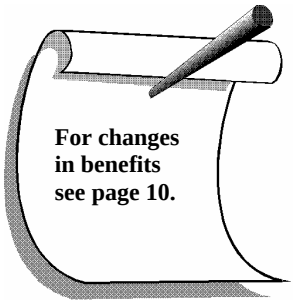
Rural Carrier Benefit Plan

http://www.nrlca.org

2006

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 and retired rural letter carriers of the U.S. Postal Service may enroll in this Plan. To enroll you must already be, or must immediately 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 the Secretary for your State Association or the membership office of 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

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

RI 72-005

Notice of the United States Office of Personnel Management's Privacy Practices

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

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the Government Accountability Office (GAO) when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

Important Notice from the Rural Carrier Benefit Plan About Our Prescription Drug Coverage and Medicare

OPM has determined that the Rural Carrier Benefit Plan prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and the Rural Carrier Benefit Plan will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

You can get more information about Medicare prescription drug coverage from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Table of Contents

Introduction

This brochure describes the benefits of the Rural Carrier Benefit Plan under our contract (CS 1073) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by the Mutual of Omaha Insurance Company, Omaha, Nebraska. The address for the Rural Carrier Benefit Plan administrative office is:

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2006, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2006, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

  Call the provider and ask for an explanation. There may be an error.

  If the provider does not resolve the matter, call us at 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:
United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

- Do not maintain as a family member on your policy:

  Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

  Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

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

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

2. **Keep and bring a list of all the medicines you take.**
   - Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
   - Tell them about any drug allergies you have.
   - Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
   - Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
   - Read the label and patient package insert when you get your medicine, including all warnings and instructions.
   - Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
3. **Get the results of any test or procedure.**
   - Ask when and how you will get the results of tests or procedures.
   - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
   - Call your doctor and ask for your results.
   - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
   - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
   - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
   - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
   - Ask your doctor, "Who will manage my care when I am in the hospital?"
   - Ask your surgeon:

     Exactly what will you be doing?

     About how long will it take?

     What will happen after surgery?

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

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this fee-for-service plan

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

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

General features of our High Option

We also have a Preferred Provider Organization (PPO):

Our fee-for-service plan offers services through a PPO. When you live in a PPO network area and use our PPO providers, you will receive covered services at reduced cost. Mutual of Omaha is solely responsible for the selection of PPO providers in your area. Contact us at 1-800/638-8432 or go to the Mutual of Omaha Website, 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. Contact the Rural Carrier Benefit Plan Administrative Office to request a PPO directory.

The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. When you use a PPO hospital, keep in mind that the health care professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not all be preferred providers in our PPO. If they are not, we will pay them as non-PPO providers.

The Plan has PPO networks in all states except for Vermont.

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.

Your Rights

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

- 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, Second Floor, Alexandria, VA 22314-3466. You may also contact us by fax at 1-703/684-9627 or visit our Website at www.nrlca.org.

Section 2 How we change for 2006

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

Program-wide changes

- In Section 3, under **Covered providers**, Arizona and West Virginia are designated as medically underserved areas in 2006. Texas is no longer designated as a medically underserved area in 2006.

Changes to this Plan

- Your share of the non-Postal premium will decrease by 13.9% for Self Only or 18.9 % for Self and Family.
- The brand name copayments for the Plan's mail order prescription drug program will increase as follows: (see page 49)

  Non-Medicare $28 preferred brand/$45 non-preferred brand

  Medicare $18 preferred brand/$35 non-preferred brand
- We now have a separate copayment for services received from a PPO specialist physician. The specialist copayment will be $30 per day (see pages 22, 23, 25, 26, 30, 41).
- We now pay 85% for professional ambulance services by either a PPO provider or a non-PPO provider after the calendar year deductible (see pages 39, 41).
- We now provide benefits for a medically necessary hearing examination. After the calendar year deductible, the Plan will pay 85% for services by a PPO provider or 75% for services by a non-PPO provider (see page 23).

Section 3 How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at 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 electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800/638-8432 or write to us at Rural Carrier Benefit Plan, 1630 Duke Street, Second Floor, Alexandria, VA 22314-3466. You may also request replacement cards through our Web site: www.nrlca.org.

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 live in the PPO network area and 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.

A specialist is a physician who provides covered services in a medical field other than family practice, internal medicine, general practice and pediatrics.

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 that 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.

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

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved". For 2006, the states are: Alabama, Alaska, Arizona, Idaho, Kentucky, Louisiana, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, West Virginia and Wyoming.

- **Covered facilities**

Covered facilities include:

- **Hospital**

1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); or

2) 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:

a) 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 its premises or under its control; or

b) 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.

For treatment of mental health and substance abuse, hospital also includes a freestanding residential treatment facility approved by the JCAHO.

In no event shall the term hospital include a convalescent nursing home or institution or part thereof that:
1) Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged;

2) Furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or

3) 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.
- **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:
  1) Administers and provides hospice care; and

  2) 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 JCAHO; or
     - Meets the standards established by the National Hospice Organization.

What you must do to get covered care

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

- **Transitional care**

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

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

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

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

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

How to get approval for…

- **Your hospital stay**

Precertification is the process by which – prior to your inpatient hospital admission or residential treatment care – 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 doctor 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 or residential treatment care 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 doctor, or your hospital must call us at 1-800/638-8432 before admission or care.
- 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 doctor, 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 the hospital stay.
- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, 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 doctor or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your doctor 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 or residential treatment care – needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

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

- If we determine that the stay was medically necessary, we will pay the inpatient charges, 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.

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.

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 (see Section 5(a))
- Organ/Tissue transplants (see Section 5(b))
- Skilled nursing care (see Section 5(c))
- Hospice care (see Section 5(c))
- Mental health and substance abuse treatment (see Section 5(e))

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, facility, pharmacy, etc., when you receive services.

Example: When you see your PPO physician you pay a copayment of $20 per day. If you see more than one PPO physician on the same day, you pay one copayment for each different physician seen on that day. When you have a stay in a PPO hospital, you pay $100 for the first day of your hospital stay and for a non-PPO hospital; you pay $300 for the first day of your hospital stay.

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 for PPO services is $350 per person and for non-PPO services it is $400 per person. 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 $700 for PPO services and $800 for non-PPO services.
- We have a separate prescription drug deductible of $200 per person each calendar year that applies to all covered prescription drugs that you purchase at a retail drugstore or pharmacy.
- We also have separate deductibles for dental care of $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.

When you live in the Plan's PPO area, you should use a PPO provider whenever possible. The following two examples explain how we will handle your bill when you go to a PPO provider and when you go to a non-PPO provider. When you use a PPO provider, the amount that you pay will usually be much less.

- **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 or copayment. Here is an example about coinsurance: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just – 15% of our $100 allowance ($15). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his bill.

Follow these procedures when you use a PPO provider to receive PPO benefits:

-Verify with us that your home address is correct
-When you make an appointment, verify that the physician or facility is still a PPO provider
-Present your Rural Carrier Benefit Plan ID card at the time that you receive services to receive PPO benefits
-Do not pay a PPO provider at the time that you receive services, except for any copayment or deductible that you owe. PPO providers will bill us directly and we will pay them. The PPO provider will then bill you for any balance due after we pay them.

- **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 catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

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

- $3,000 per person or $3,500 per family when you use PPO providers/facilities, or
- $3,500 per person or $4,000 per family when you use PPO and non-PPO providers/facilities combined
- $8,000 per person for out-of-network Mental Health/Substance Abuse care

Your out-of-pocket maximum does not include the following:

- Copayments, except the hospital stay copayment
- Coinsurance and copayments you pay for prescription drugs obtained through a Caremark network or non-network retail and/or mail-order pharmacy
- Expenses for dental care
- Expenses in excess of our allowances or maximum benefit limits
- Expenses for a stay in a skilled nursing facility
- Any penalty you pay for failing to get approval for a hospital stay or residential treatment care
- Any amount you pay for failing to get approval for additional days in the hospital after the initial length of a hospital stay is approved
- 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 care treatment program
- Expenses you pay for services, supplies and drugs not covered by us.

Carryover

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

When Government facilities bill us

Facilities of the Department of Veteran 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 do not have Medicare

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

If you…

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

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

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

If your physician…	Then you are responsible for…
Participates with Medicare or accepts Medicare assignment for the claim 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 permitted to collect only 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 (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. 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 that 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 the "limiting charge" or the physician's charge (whichever is less) and our payment combined with Medicare's payment.

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

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

High Option Benefits

See page 10 for how our benefits changed this year. Pages 74-75 are a benefits summary for the high option.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $350 per person for PPO services and $400 per person for non-PPO services ($700 per family for PPO services and $800 per family for non-PPO services). 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.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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.

Benefits 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 (except surgery)
• In a physician's office
  • Medical consultations
  • Injections
Note: We pay for surgery services by a physician under Surgical services Section 5(b).
Supplies provided by a physician during an office visit are covered under Section 5(a) of the brochure.
Outpatient physical therapy, occupational therapy, and speech therapy are covered under Section 5(a).
Treatment for Mental and Nervous Disorders, Alcoholism and Substance Abuse is covered under Section 5(e).
	PPO: $20 copayment (No deductible), $30 copayment for specialist care (No deductible)
	Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

Professional services of physicians (except surgery) • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • In your home • Contraceptive devices supplied by a physician Note: We cover contraceptive drugs under Prescription Drug Benefits, 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: *Telephone consultations, mailing, faxes, emails or any other communication to or from a physician, hospital or other medical provider.*	*All charges*
Lab, X-ray and other diagnostic tests	**You pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI Scans/PET Scans • Ultrasound • Electrocardiogram and EEG • Sonograms • Hearing test (when medically necessary)	PPO: 15% of 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	
A routine physical exam – one per person each calendar year	PPO: $20 copayment (No deductible), $30 copayment for specialist care (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

Routine screenings, limited to: • One non-fasting total blood cholesterol test – every year • Chlamydial infection • Prostate Specific Antigen (PSA) test – every year for men starting at age 40 • Cervical cancer screening (pap smear)—every year for women starting at age 18. Note: If you see another physician for your pap smear, the office visit will be covered. • Routine mammogram –every year for women starting at age 35 • Osteoporosis screening – every year starting at age 60 • Colorectal cancer screening, including – Fecal occult blood test – every year starting at age 40 – Sigmoidoscopy – every five years starting at age 50 – Colonoscopy – every ten years starting at age 50 Note: Lab tests and X-rays are covered under Lab, X-ray and other diagnostic tests, Section 5 (a).	PPO: 15% of Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Immunizations, limited to: • Influenza and pneumonia vaccine – every year • Hepatitis (types A and B) for members with increased risk or family history • Tetanus-diphtheria (Td) booster— once every 10 years	PPO: 15% of 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.	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 (including laboratory tests) • Delivery • Postpartum care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 14 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, your representative, your physician or your hospital must precertify the extended stay. • 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 cover the initial routine examination of your newborn infant covered under your family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits, Section 5(c) and Surgical services, Section 5(b). • One routine sonogram	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.*	*All charges.*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgical implant of contraceptive drugs • Injection of contraceptive drugs (such as Depo provera) • Fitting, inserting or removing Intrauterine devices (such as diaphragms or IUDs) Note: We cover contraceptive drugs and devices under Diagnostic and treatment services, Section 5(a).	PPO: $20 copayment (No deductible) for non-surgical services, $30 copayment for specialist care (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount for non-surgical services
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, except as shown in *Not covered* • Initial diagnostic tests and procedures done only to identify the cause of infertility. • Fertility drugs, hormone therapy and related services • Medical or surgical procedures done to create or enhance fertility	PPO: 15% of the Plan allowance up to $5,000 then all charges Non-PPO: 25% of the Plan allowance up to $5,000 and any difference between our allowance and the billed amount Note: The Plan will pay up to $5,000 per person per lifetime for covered infertility services, including prescription drugs.

Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* – *artificial insemination* – *in vitro fertilization* – *embryo transfer and gamete intra-fallopian transfer (GIFT)* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*
Allergy care	**You pay**
Allergy testing, injections and treatment, including materials (such as allergy serum)	Services in a physician's office --$20 copayment (No deductible), $30 copayment for specialist care (No deductible) Services outside the physician's office—15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Note: The allergy services are included in the office visit copayment if performed during an office visit with a PPO provider.
Not covered: • *RAST tests* • *Food tests* • *End point titration techniques* • *Sublingual allergy desensitization* • *Hair analysis*	*All charges*

Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 34. • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) • Respiratory and inhalation therapies Note: Drugs used in treatment therapies are covered under Prescription drug benefits 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 Note: The Plan pays for services, supplies, and tests rendered for the direct treatment of cancer under Special features, Section 5(g). Note: The Plan pays for services, supplies, and testing for kidney (renal) dialysis under Special features, Section 5(g).
Physical and occupational and speech therapies	
For physical therapy, speech therapy and occupational therapy: • 90 total combined visits per calendar year for all three listed therapies provided by: – qualified physical therapists; – qualified physicians; – speech therapists; and – occupational therapists. Note: We cover physical and occupational therapy to restore a bodily function only when there has been a total or partial loss of bodily functions because of an illness or injury and when the physician: 1) orders the care; 2) identifies the specific professional skills the patient needs and the medical necessity for skilled services; and 3) indicates the length of time the services are needed. Note: Inpatient physical, occupational and speech therapies are covered under Section 5(c).	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 necessary because of 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
Vision services (testing, treatment, and supplies)	**You pay**
• One pair of eyeglasses or contact lenses to correct a change in sight caused directly by an accidental eye injury or intraocular surgery (such as for cataracts), within one year of the injury or surgery Note: See Special Features, Section 5(g), for our benefit for routine eye examinations, including eye refractions.	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: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Refractive eye surgery* and related services	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
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 5(b) for coverage of the surgery to insert the device and Section 5(c) for services provided by a hospital.	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 and other supportive devices for the feet* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Corsets, trusses, elastic stockings, support hose and other supportive devices, unless we determine their medical necessity*	*All charges.*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: • Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); • Are medically necessary; • Are primarily and customarily used only for a medical purpose; • Are generally useful only to a person with an illness or injury; • Are designed for prolonged use; and • Have a therapeutic purpose in the treatment of an illness or injury We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as: • Hospital beds • Oxygen • Dialysis equipment • Wheelchairs • Crutches • Walkers • Colostomy and ostomy supplies • 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
Not covered: • *Sun or heat lamps, whirlpool bath, heating pads, air purifiers, humidifiers, air conditioners and exercise devices*	*All charges.*

Home health services	You pay
If home health services are precertified, 90 visits per calendar year up to a maximum plan payment of $80 per visit 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 visit and all charges after the 90 visits per calendar year Non-PPO: (No deductible); all charges after we pay $80 per visit and all charges after the 90 visits per calendar year
If home health services are not precertified, 40 visits per calendar year up to a maximum plan payment of $40 per visit. Note: All visits for home health care services, whether precertified or not, are combined and cannot exceed 90 visits per calendar year. Note: All therapy services will count toward the 90-day therapy visit limitation per calendar year, as listed under Physical, occupation and speech therapy in Section 5 (a)	PPO: (No deductible); all charges after we pay $40 per visit and all charges after the 40 visits per calendar year Non-PPO: (No deductible); all charges after we pay $40 per visit and all charges after the 40 visits per calendar year
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services consisting of only hygiene, feeding, exercising, moving the patient, homemaking, companionship, or giving oral medication* • *Custodial care as defined in Section 10*	*All charges.*
Chiropractic	
• Manipulation of the spine and extremities	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	
Acupuncture – performed by a doctor of medicine (M.D.) or osteopathy (D.O.), an oriental medical doctor (O.M.D.) or licensed acupuncturist (L.Ac.) for: • Anesthesia • Pain relief • Therapeutic purposes Note: Please see the definition of acupuncture in Section 10.	PPO: Nothing up to the Plan maximum of $20 per visit and all charges over $20 per visit and/or 30 visits per person each calendar year. Non-PPO: Nothing up to the Plan maximum of $20 per visit and all charges over $20 per visit and/or 30 visits per person each calendar year.

Not covered: • *Naturopathic services* • *Chelation therapy, except for arsenic, gold, lead or mercury poisoning and the use of desferoxamine for iron poisoning*	*All charges.*
Educational classes and programs	**You pay**
Coverage is limited to: • Smoking Cessation – Up to $100 maximum per person per calendar year, including: - Individual/Group counseling - Over-the-counter (OTC) drugs for smoking cessation	Nothing up to the $100 maximum benefit, then all charges
Physician office visits for Smoking Cessation Note: Prescription drugs are covered under Prescription drug benefits, Section 5(f).	PPO: $20 copayment (No deductible), $30 copayment for specialist care (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $350 per person for PPO services and $400 per person for non-PPO services ($700 per family for PPO services and $800 per family for non-PPO services). 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.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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.**

Benefits 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	
A comprehensive range of services, such as: • Surgical procedures, including delivery of a newborn and circumcision • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 20% 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 (bariatric surgery) -- a condition where a person (1) is the greater of 100 pounds or 100% over his or her normal weight (based on the Plan's guidelines) with medical complications; (2) is age 18 or older; and (3) has maintained this condition for at least five years with documented evidence of unsuccessful attempts to reduce weight by following a diet and exercise program monitored by a physician • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons- we cover up to 20% of our allowance for the surgeon's charge For related services, see the applicable benefits section (i.e., for inpatient hospital benefits, see Section 5 (c).	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 20% 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: 80% of the reasonable and customary charge • For the secondary procedure(s): – PPO: 90% of one-half of the Plan allowance or – Non-PPO: 80% 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: 20% of the Plan allowance for the primary procedure and 20% 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: • *Reversal of voluntary sterilization* • *All refractive eye surgeries and similar services* • *Dental appliances, study models, splints, and other devices or service related to the treatment of TMJ dysfunction* • *Treatment or removal of corns and calluses, or trimming of toenails.* • *Mutually exclusive procedures-- surgical procedures that are not generally performed on one patient on the same day.*	*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 the 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 or 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 for coverage, 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: 20% 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 impacted (unerupted) teeth • Excision of cysts and incision of abscesses when done as independent procedures • Dental surgical biopsy • Other surgical procedures that do not involve the teeth or their supporting structures • Surgical correction of temporomandibular joint (TMJ) dysfunction • Frenectomy and frenotomy not as a result of orthodontic care	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

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	**You pay**
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single or double lung transplants limited to the patients –for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, emphysema or cystic fibrosis • Pancreas (when condition is not treatable by insulin use) • Allogeneic bone marrow transplants – only for patients with acute leukemia, advanced Hodgkin's disease • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas for irreversible intestinal failure 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. Note: Mutual of Omaha has special arrangements with 15 transplant 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. Your physician can coordinate arrangements by calling Mutual of Omaha at 1-800/638-8432.	PPO: 10% of the Plan allowance (No deductible). Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible).

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*	*All charges.*
Anesthesia	**You pay**
Professional services provided in : • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Physician's office	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 20% 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 things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". The calendar year deductible is: $350 per person ($700 per family) for PPO services and $400 per person ($800 per family) for non-PPO services. The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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 Sections 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.

Benefits Description	You pay
Note: The calendar year deductible applies ONLY when we say below:-"(calendar year deductible applies)".	
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets 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.	PPO: $100 copayment for each hospital stay Non-PPO: $300 per copayment for each hospital stay and 20% of the covered 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.

Inpatient hospital – continued on next page.

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Rehabilitative services • 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 Note: Take-home medical supplies, equipment, orthopedic and prosthetic devices are covered under Section 5(a). Note: Take-home drugs are covered under Section 5(f). Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the anesthesiologist bills, we pay Anesthesia benefits. If preadmission testing is performed in the hospital as inpatient then we pay pre-admission tests at the same coinsurance rate as inpatient miscellaneous charges.	PPO: Nothing Non-PPO: 20% of charges
Not covered: • *Any part of a hospital admission that is not medically necessary (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* • *Hospital charges for non-covered surgery* • *Custodial care (see definition)even when provided in a hospital* • *Non-covered facilities, such as nursing homes, rest homes, convalescent homes, facilities for the aged, 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 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 • Pre-surgical testing • 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 even if we do not cover the dental procedures. Note: Take-home supplies, medical supplies, equipment, orthopedic and prosthetic devices are covered under Section 5(a). Note: Take-home drugs are covered under Section 5(f). 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: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)
Extended care benefits/Skilled nursing care facility benefits	
If care is precertified, we cover semiprivate room and board services and supplies in a Skilled Nursing Facility (SNF) for up to 60 days per calendar year when: • The stay is medically necessary • The stay is under the supervision of a physician	PPO: Charges in excess of the 60-day maximum Non-PPO: Charges in excess of the 60-day and the difference between the Plan allowance and the billed amount
If care is not precertified, we cover semiprivate room and board services and supplies for up to 30 days per calendar year, subject to the above conditions. Note: Precertified and not precertified days are combined and cannot exceed 60 days in a calendar year.	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. **If care is precertified,** we pay up to $7,500 for inpatient or outpatient hospice care. Note: We pay for a hospice program once per lifetime. This benefit does not apply to services covered under any other benefit of the Plan.	Nothing up to $7500, then all charges
If the care is not precertified, we pay up to $5,500 for inpatient or outpatient hospice care. Note: We pay for a hospice program once per lifetime. This benefit does not apply to services covered under any other benefit of the Plan.	Nothing up to $5,500, then all charges
Not covered: • *Private duty nursing* • *Custodial care*	*All charges.*
Ambulance	**You pay**
• Professional ambulance service to the nearest facility equipped to handle the patient's condition	PPO: 15% of the Plan allowance (calendar year deductible applies) Non-PPO: 15% of the 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* • *Ambulance transportation for your own or your family's convenience*	*All charges.*

Section 5(d) Emergency services/accidents

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $350 per person for PPO services and $400 per person for non-PPO services ($700 per family for PPO services and $800 per family for non-PPO services). 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.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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.

What is an accidental injury?

An accidental injury is a bodily injury that requires immediate medical attention and is sustained solely through violent, external, and accidental means, such as broken bones, animal bites, insect bites and stings and poisonings. An accidental dental injury is covered under Dental benefits, Section 5(h).

Benefits 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 up to the Plan allowance for: • Emergency room facility charge and emergency room physician charge; or • First physician office visit for accidental injury Note: We pay Hospital benefits if you are admitted.	PPO: Nothing (No deductible) Non-PPO: Nothing (No deductible)
Note: We pay for the services performed outside of the emergency room under the appropriate Plan benefit. Note: We pay for services received in the emergency room, but billed in addition to the facility charge, such as x-rays, laboratory, pathology and diagnostic tests, under Section 5(a). Note: We pay for services performed at the time of the first office visit such as x-rays, laboratory tests, drugs, or any supplies or other services under Section 5(a).	

Medical emergency	
Regular Plan benefits are paid for care you receive because of a medical emergency (non-accident) like a heart attack or stroke.	PPO: **Services in a physician's office**-- $20 copayment (No deductible), $30 copayment for specialist care (No deductible) **Services outside the physician's office—**15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Ambulance	**You pay**
Professional ambulance service to the nearest facility equipped to handle the patient's condition, including air ambulance when medically necessary Note: See 5(c) for non-emergency service.	PPO: 15% of the Plan allowance Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Ambulance transport for your own or your family's convenience*	*All charges.*

Section 5(e) Mental health and substance abuse benefits

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

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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 benefits begin on page 44.

Benefits 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 responsibilities are no greater than for other illnesses or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management (preauthorization not required)	15% of Plan allowance (No deductible for outpatient physician visits) $20 copayment (No deductible)
• Diagnostic tests including psychological testing	15% of Plan allowance

In-Network benefits – continued on next page.

In-Network benefits *(continued)*	**You pay**
• Services provided by a hospital or other facility as an inpatient, including residential treatment centers	$100 copayment for each hospital stay (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 - 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 intensely 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* • *All charges (including room and board) for chemical aversion therapy, conditioned reflex treatments, narcotherapy, and similar aversion treatments* • *Counseling or therapy for educational or behavioral problems, mental retardation or learning disabilities* • *Counseling or therapy services for marital problems* • *Community based programs such as self-help groups or 12-step programs* *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 and Precertification	To be eligible to receive these enhanced mental health and substance abuse benefits you must obtain a treatment plan and follow all of the following network authorization processes: These include: • Precertification to establish the medical necessity of your stay in a hospital, residential treatment center or other facility. Please see page 13 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 pages13 and 14 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 any available 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 14, 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 any available benefits by 50%.
Network deductibles and out-of-pocket maximums	A $350 per person for PPO services ($700 per family) 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 17), the Plan will pay 100% of its allowance for the rest of the calendar year.
Network limitation	If you do not obtain an approved treatment plan, we will provide only Out-of-Network benefits.
How to submit Network claims	Follow the normal claim procedure on page 56.

Out-of-Network benefits	**You pay**
Inpatient mental health care benefits We pay 80% of room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets	$300 copayment for each hospital stay and 20% of room and board charges (No deductible)
We pay 80% of other hospital services and supplies, such as: • Prescribed drugs and medicines • Diagnostic laboratory tests • Medical supplies and equipment Note: This includes residential treatment centers.	20% of charges (no deductible)

Services in alternate care settings
• 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
  - 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 intensely 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 mental health or substance abuse treatment sessions • We pay for mental health/substance abuse 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)
• Medication management • Diagnostic testing (including psychological testing)	25% of the Plan allowance and any difference between our allowance and the billed amount
Substance abuse benefit We will pay up to a maximum of $11,000 per person per lifetime for inpatient treatment in an accredited facility, residential treatment center, or for an outpatient treatment program.	Nothing up to $11,000, then all charges
Not covered out-of-network: • *Services we have not approved* • *All charges (including room and board) for chemical aversion therapy, conditioned reflex treatments, narcotherapy, and similar aversion treatments* • *Counseling or therapy for educational or behavioral problems, mental retardation or learning disabilities* • *Counseling or therapy services for marital problems* • *Community based programs such as self-help groups or 12-step programs*	*All charges.*

Precertification	Follow the normal procedure on page 13 to get approval for your hospital stay, residential treatment care, 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. Please see page 17.
How to submit out-of-network claims	Follow the normal claim procedure on page 56.

Section 5(f) Prescription drug benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 49.
- 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 prescription drug deductible is $200 per person each calendar year. This is a separate deductible from the Plan's calendar year deductible and applies to prescription drugs that you buy at any network or non-network retail drugstore or pharmacy. The prescription drug deductible applies to almost all benefits in this Section. We added ("No deductible") to show when the prescription drug deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- 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.

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

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 participating pharmacy, a non-network pharmacy, or through the Caremark mail order prescription program.

- **Caremark participating pharmacy**

  You may fill your prescription at a Caremark participating pharmacy. To find a participating pharmacy where you live, call Caremark toll-free at 1-888/232-8482 or on the Internet at www.Caremark.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 the Caremark prescription drug card to receive the negotiated discount price.** You pay the coinsurance and any deductible, if applicable, for your prescription. You do not need to file a claim when you use a Caremark participating pharmacy and show your Plan ID card or the Caremark prescription drug card. The participating pharmacy will file the claim with Caremark for you. **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. If you do not show your ID card or Caremark drug card at a participating pharmacy, you will need to file a claim with Caremark.**

- **Non-participating 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 Caremark.

- **Caremark mail order pharmacy**

  You may fill your long-term prescription through the Caremark mail order pharmacy. You will receive order forms and information on how to use the mail order prescription program from Caremark. 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, P O Box 659572, San Antonio, TX 78256-9572; 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 1-888/232-8482 or on the Internet at www.Caremark.com

- **Caremark's primary drug list**

  Caremark's primary drug list is a list of preferred brand name prescription medications that are chosen based on their clinical effectiveness and cost.

- **These are the dispensing limitations.**

- You may purchase up to a 34-day supply of medication at any Caremark participating pharmacy. There is a limit on the

Prescription drug benefits *(continued)*

number of refills that you can buy at a Caremark participating pharmacy for long-term maintenance medications (prescription medications that you take every day). You can buy an initial 34-day supply and two refills for long term maintenance medications at a Caremark participating pharmacy during any twelve month period. After you buy the initial supply and two refills at a Caremark participating pharmacy, you must purchase your long-term maintenance medications through the Caremark mail order pharmacy to have the prescription covered by the Plan.

- There is also a 34 day supply limit for prescriptions that you buy at a non-participating pharmacy. In addition, you are limited to an initial 34 day supply plus two refills for long-term maintenance medications that you buy at a non-participating pharmacy. You pay the full regular price for any prescription that you buy at a non-participating pharmacy and then file a claim with Caremark for reimbursement after you satisfy the annual $200 prescription drug deductible (see pages 48 and 49).
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you have to pay the difference in copayment between the name brand drug and the generic.
- 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 suppositories
    - Vaccines
    - Frozen medications
    - Dental products
    - Most medical devices
    - Infertility drugs
    - Medications in unit dose packaging

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.

- Caremark has a primary drug list for its mail order prescription program. The primary drug list is a list of preferred (not required) brand name prescription medications. If your physician believes a brand name drug is necessary that is not on Caremark's primary drug list, you will pay a higher copayment for the non-preferred brand name drug. To request a copy of the Caremark Primary Drug List, call the Caremark Customer Service Department toll-free at 1-888/232-8482.
- 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 participating pharmacy or at a non-participating pharmacy. However, your copayment is reduced for prescriptions that you order through the Caremark mail order prescription program.

Prescription drug benefits – continued on next page

Prescription drug benefits *(continued)*

- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under Federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. All manufacturing and marketing of a generic drug is conducted following strict guidelines established by the U.S. Food and Drug Administration (FDA). No prescription drug can be sold in the U.S. without FDA approval. The manufacturing facilities of all drug companies, whether they make generic or brand name drugs, must pass stringent, regular inspections by the FDA. There is no difference between the standards set for drug companies that make brand name or generic medications. Many drug companies that make brand name drugs also make generic drugs. A generic prescription costs you -- and us -- less than a name brand prescription.
- **When you do have to file a claim.** If you use a Caremark participating pharmacy, the pharmacy will file the claim for you electronically. If you use a non-participating pharmacy, you will need to file a claim with Caremark. Use the Caremark prescription claim form and send your claim to:

Caremark

Attention: Claims Department

P O Box 686005

San Antonio TX 78268-6005

Claims for prescription drugs and supplies that are not ordered through the Caremark mail order prescription program must include receipts that have the patient's name, the prescription number, name of the drug or supply, prescribing physician's name, date charge, and pharmacy name. The pharmacist must sign any computer printout or pharmacy ledger. Prescription claims forms are available by calling toll-free 1-888/232-8482 or at our Website at www.nrlca.org

Benefits 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 and administered 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 those listed as *Not covered*. • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Colostomy and ostomy supplies (Network and Non-Network Retail only)	• Network Retail: 30% of cost • Network Retail Medicare: 30% of cost • Non-Network Retail: 30% of cost • Non-Network Retail Medicare: 30% of cost • Network Mail Order: $15 generic/$28 brand name on primary drug list/$45 brand name not on primary drug list (No deductible) • Network Mail Order when Medicare Part B pays first: $8 generic/$18 brand name on the primary drug list/$35 brand name not on the primary drug list (No deductible) Note: If there is no generic equivalent available, you will still have to pay the brand name copayment. Note: For long-term maintenance medications you are limited to the initial prescription and two refills at a Caremark participating pharmacy. You must use the mail order program for a continuing supply of medication.
If you are provided drugs directly by a physician or covered facility (not a pharmacy), including FDA-approved drugs and devices requiring a physician's prescription for the purpose of birth control; If you do not use your prescription drug card to purchase needles and syringes for the administration of covered medications or diabetic supplies; If you do not use your prescription drug card to purchase colostomy or ostomy supplies	30% (No deductible)
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 feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to 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	We provide Plan members and their eligible dependents with access to a 24-hour-a-day nurse help line through the Optum Nurse Line Program. For any of your health concerns, 24 hours a day, 7 days a week, you may call Optum NurseLine toll-free at 1-866/796-1857 and talk with a registered nurse who will discuss treatment options and answer your health questions and concerns.
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
Health maternity program	You have access to Mutual of Omaha's Healthy Maternity Program, which provides educational material and support to pregnant women. Contact Customer Service toll-free at 1-800/638-8432 for more information.

Disease management programs	Healthydirections[sm], is our disease management program for congestive heart failure (CHF). Your health is important to us! If you have congestive heart failure (CHF), we will contact you to participate in this voluntary program. If you would like to contact us for more information about this program, please call us toll-free at 1-800/638-8432. Healthydirections[sm] , is provided at no additional cost to you. The program provides education and management programs through: • Nurse support • Education about the disease and how it affects your body • Proper medical management that can help lead you to a healthier lifestyle You and your physician remain in charge of your treatment plan. CarePatterns® is provided at no additional cost to you. The program is voluntary and provides education and management programs for: • Diabetes • Asthma, including pediatric asthma • Osteoarthritis • Chronic Obstructive Pulmonary Disease (COPD) • Coronary Artery Disease (CAD) Note: CarePatterns® programs are provided through Caremark, our prescription benefit management company. For more information on CarePatterns® programs, call toll-free 1-800/227-3728.
Travel benefit/services overseas	We have entered into an agreement with Lifeguard Emergency Travel, Inc. (Lifeguard) to provide Plan members and their eligible dependents with a travel assistance program. If you or a family member becomes sick or injured while traveling more than 100 miles away from home you can call Lifeguard 24-hours-a-day, 7 days a week from anywhere in the world for assistance. You may call toll-free at 1-888/965-9500 or collect at 1-817/416-4960 when you are outside the toll-free calling area.

Section 5(h) Dental benefits

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $50 per person. The dental deductible applies to almost all benefits in this Section. We added ("No deductible") to show when the dental 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.

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.

Accidental injury benefit	You pay
The Plan will pay for the treatment or repair (including root canal therapy and crowns) of an accidental injury to sound natural teeth (not from biting or chewing). 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.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Dental benefits	**Class A Schedule**	
Service	**We pay (scheduled allowance)**	**You pay**
The plan pays actual charges for up to two preventive care visits per person each calendar year up to the scheduled Plan allowance (No deductible)		All charges that exceed the Plan's scheduled allowance for the service
Oral exam	$12.50 twice each calendar year	
Prophylaxis, adult	$22.00 twice each calendar year	
Prophylaxis, child (thru age 14)	$15.00 twice each calendar year	
• with fluoride treatment	$24.00 twice each calendar year	
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	**Class B Schedule**	
Service	**We pay (scheduled allowance)**	**You pay**

After a deductible of $50 per person during the calendar year, the Plan pays actual charges up to the scheduled allowance for each service. There is no annual limit on the amount of services you receive.		All charges that exceed the Plan's scheduled allowance for the service
Restorations		
1 surface deciduous	$12.50	
2 surface deciduous	$18.50	
3 surface deciduous	$23.50	
1 surface permanent	$14.00	
2 surface permanent	$20.50	
3 or more surface permanent	$26.50	
Gold restoration	$103.50	
Extractions		
Single tooth	$16.00	
Each additional tooth	$15.00	
Pulp capping-direct	$9.50	
Pulpotomy-vital	$21.00	
Root canal therapy		
This includes the actual root canal treatment and any retreatments		
One root	$106.00	
Two roots	$126.00	
Three or more roots	$170.00	
Periodontics		
Gingival curettage (per quadrant)	$26.50	
Crowns/abutments		
Resin and Resin with metal	$120.00	
Porcelain	$113.50	
Porcelain with gold	$120.00	
Gold (full cast and ¾ cast)	$120.00	
Prefabricated resin and stainless steel	$21.50	

Pontics		All charges that exceed the Plan's scheduled allowance for the service
Porcelain and Porcelain with gold	$120.00	
Dentures		
Complete upper or lower	$126.00	
Partial without bar	$138.00	
Partial with bar	$157.00	
Repairs (dentures and partials)	$14.00	
Denture 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—The NRLCA Long Term Care Plan through Mutual of Omaha Insurance Company is open to all 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 NRLCA Group Long-Term Care Insurance brochure for detailed information. This insurance plan is separate from the Federal Long Term Care Insurance Program.

- 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 through Hartford Life Insurance Company protects an individual from being unable to work and earn a paycheck because of an illness or injury. The RLCLTD Plan is available to all active regular rural letter carriers who are members of the NRLCA. Premium rates are based on your age and benefit level selected. Please consult the NRLCA Voluntary Long Term Disability Income Protection Plan brochure 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 through Ameritas Life Insurance Company is available to all NRLCA members. The Plan features a schedule of benefits for a variety of dental care services. The Plan allows members to use any licensed dentist. 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 NRLCA Ameritas Dental Plan brochure for detailed information.

Term life insurance—The NRLCA Life Insurance Plan through Mutual of Omaha Insurance Company 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 NRLCA Life Insurance Plan brochure 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 enrollee

Vision insurance—The NRLCA Vision Plan through Vision Service Plan (VSP) is available to all members of the NRLCA. Please see the NRLCA Vision Plan brochure for complete information

- Provides discounts on frames, lenses, and contact lenses at participating providers

- Provides discounts on laser eye surgery at selected locations

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

NRLCA Group Insurance Department
1630 Duke Street, 2nd 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. Even if a covered provider prescribes, recommends, or approves a service or supply does not make it medically necessary or eligible for coverage.

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
- 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;
- 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 18), physician charges exceeding the amount specified by the U.S. Department of Health and Human Services when benefits are payable under Medicare (limiting charge) or State premium taxes however applied;
- Custodial care;
- Services, drugs, or supplies related to weight control or any treatment of obesity except surgery for morbid obesity;
- Nonmedical services such as social services and recreational, educational, visual, and nutritional counseling;
- Hearing aids and examinations for them;
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices;
- Services, drugs and supplies for cosmetic purposes, except repair of accidental injury;
- Charges for completion of reports or forms;
- Charges for interest on unpaid balances;
- Charges for missed or cancelled appointments;
- Charges for telephone consultations, conferences, or treatment by telephone, mailings, faxes, e-mails or any other communication to or from a hospital or covered provider;
- Biofeedback, conjoint therapy, hypnotherapy, and milieu therapy;
- Preventive medical care and services, except those provided under Preventive care adult and Preventive care children in Section 5(a);
- Private duty nursing care that you receive during a hospital stay
- Any services you receive related to a learning disability;

- Breast implants (except after mastectomy), injections of silicone or other substances, and all related charges;
- Eyeglasses and contact lenses (except as covered under Vision services in Section 5 (a); or
- Services and supplies not specifically listed as covered.

Note: Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories.

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 or at our Website at www.nrlca.org.

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 services you receive overseas or when another group health plan is primary – submit it on the HCFA-1500 or a claim form that includes the information shown below. Send your claims to:

Rural Carrier Benefit Plan

P. O. Box 668329

Charlotte, NC 28266-8329

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 Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.

Please see Prescription drug benefits, Section 5(f), for instructions on how to file a claim for prescription drugs that you buy at a local pharmacy.

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 should submit your claim within 90 days after you receive care but in no case more than two years after you receive the care. We can extend this deadline if you were prevented from filing your claim on time by administrative operations of Government or legal incapacity, provided you file the claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on reissuing 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.

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 28266-8329; 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: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.

The disputed claims process *(continued)*

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 more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

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. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

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

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 may call OPM's Health Insurance Group 2 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 or a covered family member have coverage 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.

Please see Section 4, *Your costs for covered services,* for more information about how we pay claims.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older.
- Some people with disabilities under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

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

- **Should I enroll in Medicare?**

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

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you

don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

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

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

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

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care except you do not need to get a hospital stay approved when Medicare pays first. We do not require preauthorization and concurrent review of mental health and substance abuse treatment when Medicare Part B pays first. However, when Medicare stops paying benefits for any reason, you must follow our precertification, preauthorization and concurrent review procedures.

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

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-800/638-8432.

We waive some costs if the Original Medicare Plan is your primary payer – When Original 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 $350 calendar year deductible and coinsurance for PPO services or the $400 calendar year deductible and coinsurance for non-PPO services and pay the Part B deductible for you.

NOTE: We do not waive the $200 deductible for prescription drug expenses when the medication is purchased at a retail pharmacy.

- Services and supplies provided in a hospital or other covered facility. If you are enrolled in Medicare Part A, we will waive our $100 hospital copayment for a stay in a PPO hospital or our $300 per admission hospital copayment and coinsurance for a stay in a non-PPO hospital and pay the Part A deductible for you.

- **Private Contract with your physician**

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

paid after Original Medicare's payment.

- **Medicare Advantage (Part C)**

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

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

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

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

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

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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 we use in this brochure

Acupuncture

The practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic purposes.

Admission

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

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.

Chiropractic

A system of therapy that attributes disease to abnormal function of the nervous system and attempts to restore normal function by manipulation of the spinal column and other body structures**.**

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 15.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 15.

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 is 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 15.

Experimental or 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 or 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.

Home health care agency

A public agency or private organization under Medicare that is licensed as a home health care agency by the State and is certified as such**.**

Home health care plan

A plan of continued care and treatment when you are under the care of a physician, and when certified by the physician that, without the home health care, confinement in a hospital or skilled nursing facility would be required.

Hospice care program

A coordinated program of home or inpatient pain control and supportive care for a terminally-ill patient and the patient's family. Care is provided by a medically supervised team under the direction of an independent hospice administration that we approve.

Hospital stay

An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any illness or injury. You start a new hospital stay: (1) when the admission is for a cause unrelated to the previous admission; (2) when an employee returns to work for at least one day before the next admission; or (3) when the hospital stays are separated by at least 60 days for a dependent or retiree.

Long term rehabilitation therapy

Physical, speech, and occupational therapy, which can be expected to last longer than a two month period in order to achieve a significant improvement in your condition.

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 Healthcare Charges Database (HCD). 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.

Prosthetic device

An artificial substitute for a missing body part, such as an arm or a leg, used for functional reasons, because a part of the body is permanently damaged, is absent or is malfunctioning. A prosthetic device is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.

Routine testing/screening

Healthcare services you receive from a covered provider without any apparent signs or symptoms of an illness, injury or disease.

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

Coverage information

- **No pre-existing condition limitation**

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

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

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

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

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

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

We don't determine who is eligible for coverage and, 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 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.

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2006 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2005 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **When you retire**

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **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. This is the case even when the court has ordered your former spouse to provide health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

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

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

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

Section 12 Two programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, provided by the U.S. Postal Service, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a substantial discount on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The U.S. Postal Service Flexible Spending Account Program

- **What is an FSA?**

An FSA is an account that allows you to cover your eligible health and dependent care (day care) expenses with tax-free money that you contribute from your paycheck throughout the year. By using an FSA, you can reduce your taxes while paying for services that you pay for out of your own pocket anyway. Whatever money you contribute isn't subject to Federal income tax, Social Security tax, or Medicare tax. And, the money is tax-free when you withdraw it, too.

There are two types of FSAs offered by the Postal Service:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents have. For complete information on eligible health care expenses, please see the brochure, FSA BK1, *Flexible Spending Accounts (November 2004)*, or call the FSA Customer Service Center toll-free at 1-800/842-2026.
- Eligible dependents for this account include anyone you claim on your Federal Income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. ***Note:*** The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that you can contribute to the health care flexible spending account is $5,000 for 2005. The minimum amount is $135.

Dependent Care Flexible Spending Account (DCFSA)

-
- Covers eligible dependent care expenses that you incur so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time. For complete information on eligible dependent care expenses, please see the brochure, FSA BK1, *Flexible Spending Accounts (November 2004)*, or call the FSA Customer Service Center toll-free at 1-800/842-2026.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum amount that you can contribute to the dependent care flexible spending account is $5,000 for 2005. The minimum amount is $135. For taxpayers who file their taxes separately with a spouse, the maximum is $2,500 per year. The limit includes any child care subsidy you may receive.

- **Contact the USPS FSA Program**

To find out more about the Postal Service Flexible Spending Account Program,

please call the FSA Customer Service Center toll-free at 1-800/842-2026 from 8:00 AM to 10:00 PM, Eastern Time, Monday through Friday, to talk to a representative. Postal employees who are hearing impaired may use a text messaging service (TDD) by calling toll-free 1-866/206-7810.

The Federal Long Term Care Insurance Program

- **It's important protection**

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

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP**,** you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To request an Information Kit and application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

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

Summary of benefits for the Rural Carrier Benefit Plan – 2006

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 $350PPO/$400 Non-PPO calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You pay	Page
Medical services provided by physicians:	**PPO:** $20/office visit	22
• Diagnostic and treatment services provided in the office	**Non-PPO**: 25% of our allowance and any difference between our allowance and the billed amount*	
• Surgery……	**PPO:** 10% of our allowance **Non-PPO:** 20% of our allowance and any difference between our allowance and the billed amount	31-35
Services provided by a hospital:	**PPO:** $100 copayment per admission	36-39
• Inpatient	**Non-PPO:** $300 copayment per admission; 20% of room and board and other charges	
• Outpatient	**PPO:** 15% of our allowance* **Non-PPO:** 30% of our allowance* and any difference between our allowance and the billed amount	38
Emergency benefits		
• Accidental injury	Nothing for emergency room visit and first physician office visit	40
• Medical emergency.....	Regular benefits	22-39
Mental health and substance abuse treatment	**PPO:** $100 copayment per admission	42
• Inpatient…….	**Non-PPO:** $300 copayment per admission; 20% for room and board; 20% of other charges. For substance abuse, charges over $11,000 per person per lifetime	44
• Outpatient……	**PPO:** 15% of our allowance* (no deductible on physician visits)	42-43
	Non-PPO: Charges over $75 per treatment session (no deductible). For substance abuse, charges over $11,000 per person per	44-45

	lifetime for an aftercare program (combined with inpatient)	
Prescription drugs	**Network and Non-network pharmacy:** 30% of cost* **Mail Order Pharmacy:** Up to a 90 day supply; $15/generic drug; $28/preferred brand name drug; $45/non-preferred brand name drug **Mail Order with Medicare Part B:** Up to a 90 day supply; $8/generic drug; $18/preferred brand name drug; $35/non-preferred brand name drug	46-49
Dental care	Any difference between our scheduled allowance and the billed amount	52-53
Special features: Flexible benefits option; Cancer treatment benefit; Kidney dialysis benefit; 24 hour nurse line; Travel assistance program; Routine eye exam benefit; Healthy maternity program; Disease management programs		50-51
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	**PPO:** Nothing after $3,000/person or $3,500/family per calendar year **Non-PPO:** Nothing after $3,500/person or $4,000/family per calendar year Note: Benefit maximums apply and some costs do not count toward this protection	17

2006 Rate Information for Rural Carrier Benefit Plan

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

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

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

Type	Code	*Non-Postal Premium*				*Postal Premium*	
		Biweekly		Monthly		Biweekly	
		Gov't	Your	Gov't	Your	USPS Share	Your Share
High Option	**381**	**N/A**	**N/A**	**$301.56**	**$187.35**	**$164.31**	**$61.34**
High Option	**382**	**N/A**	**N/A**	**$684.84**	**$309.90**	**$373.15**	**$85.96**