Rural Carrier Benefit Plan

http://www.nrlca.org
Customer service 1-800-638-8432

2014

A fee-for-service Plan with network providers

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2014: Page 15
- Summary of benefits: Page 96

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

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 Department of the National Rural Letter Carriers' Association.

Membership dues: Active and retired 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

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

Important Notice from the Rural Carrier Benefit Plan

About

Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

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 administered by Claims Administration Corporation, a Coventry Health Care company. Customer service may be reached at 1-800-638-8432 or through our website: http://rcbp.coventryhealthcare.com. The address for the Rural Carrier Benefit Plan administrative office is:

Rural Carrier Benefit Plan
1630 Duke Street, 2nd 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, 2014 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2014 and changes are summarized on page 15. Rates are shown at the end of this brochure.

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

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

Plain Language

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

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

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:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your 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
1-877-499-7295

OR go to: www.opm.gov/oig

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100

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

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.

- Take a relative or friend with you to help you ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have such as latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery?
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/ The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

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

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

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

- **Minimum value standard**

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

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

  See www.opm.gov/healthcare-insurance/healthcare for enrollment information as well as:

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

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

  - When you may change your enrollment;
  - How you can cover your family members;
  - What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
  - What happens when your enrollment ends; 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. For information on your premium deductions, you must also contact your employing or retirement office.

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

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

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

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

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

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

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

You can find additional information at www.opm.gov/healthcare-insurance.

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your children under age 26, 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 26 years of age or older who is incapable of self-support.

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including your marriage, divorce, annulment or when your child under age 26 turns age 26 .

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

- **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 2014 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 2013 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

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

When you lose benefits

When FEHB coverage ends

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

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

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

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

Upon divorce

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

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 26, regardless of marital status, 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. If you would like to learn more about the ACA including the health insurance marketplace, please visit www.healthcare.gov .

Finding replacement coverage

This Plan no longer offers its own non-FEHB plan for conversion purposes. If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 1-800-638-8432 or visit our website at http://rcbp.coventryhealthcare.com.

Health Insurance Marketplace

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

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/healthcare-insurance/healthcare; 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 1. How this plan works

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

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

General features of our High Option

We have Network Providers:

Our fee-for-service Plan offers services through our network providers. This means that certain hospitals and other health care providers are "in-network providers". When you live in a network area and use the Plan's network providers, you will receive covered services at reduced cost. Coventry Health Care and Aetna are solely responsible for the selection of network providers in your area. The Plan uses the Coventry Health Care National Network as In-network in all states except Ohio and New Jersey. In Ohio and New Jersey, the in-network providers are those that participate in the Aetna Choice Point of Service (POS) II Product. We encourage you to choose a primary care provider to assist in coordinating your medical care in the safest and most cost effective manner. Contact us at 1-800-638-8432 or go to our Website, http://rcbp.coventryhealthcare.com for the names of network providers and to verify their continued participation. You can also reach our Web page through the FEHB Web site, www.opm.gov/insure/health. Contact Coventry Health Care at 1-800-638-8432 to request a network directory for your area.

The Out-of-network benefits are the standard benefits of this Plan. Network benefits apply only when you use an in-network 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 network provider is available, or you do not use a network provider, the standard Out-of-network benefits apply. When you use a network facility, keep in mind that the health care professionals who provide services to you in the facility may not be in-network providers in our network. However, if the services are received at a network facility, we will pay up to the Plan allowance at the In-network provider level of benefits for services you receive from an out-of-network anesthesiologist (including Certified Registered Nurse Anesthetist (CRNA)), radiologist, pathologist, emergency room physician, surgeon and neonatologist when immediate or emergency treatment is required. You will still be responsible for the difference between our benefit payment and the billed amount.

This Plan offers you access to certain out-of-network health care providers that have agreed to discount their charges. These providers are available to you through MultiPlan, Three Rivers Provider Network (TRPN) and PMCS networks that have contracted with the Plan. Covered services provided by these participating providers are considered at the negotiated rate subject to applicable deductibles, copayments and coinsurance. Since these participating providers are not considered in-network providers, out-of-network benefit levels will apply. Contact us at 1-800-638-8432 for more information about participating providers.

The Plan has networks in all states. The Plan uses the Coventry Health Care National Network, except in Ohio and New Jersey (see above). Please check the Plan Website at: http://rcbp.coventryhealthcare.com or call Coventry at 1-800-638-8432 for network providers.

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.

We use InterQual criteria in making determinations regarding hospital stay precertification and extended stay reviews, observation stay reviews, and reviews of procedures that require precertification or authorization. (See *What you must do to get covered care* in Section 3.) These determinations can affect what we pay on a claim.

We apply the National Correct Coding Initiative (NCCI) edits published by the Centers for Medicare and Medicaid Services (CMS) in reviewing billed services and making Plan benefit payments for them.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our 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, 2nd Floor, Alexandria, VA 22314-3466. You may also contact us by fax at 1-703-684-9627 or visit our Web site at http://rcbp.coventryhealthcare.com.

Your medical and claims records are confidential

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

You may view our Notice of Privacy Practice for more information about how we may use and disclose member information by visiting our web site at: http://rcbp.coventryhealthcare.com

Section 2. Changes for 2014

Do not rely only 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

- Montana and South Dakota have been removed from the list of Medically Underserved Areas for 2014.
- Some sections of the brochure have moved and/or been combined. Please read the entire brochure for a complete description of the benefits provided by the Plan.

Changes to this Plan

- Your share of the Postal premium will increase for Self Only and for Self and Family for "Current" carriers and decrease for "New" carriers. Your share of the non-Postal premium will decrease for Self Only and for Self and Family. See the back cover for details.
- We have added a catastrophic protection out-of-pocket maximum for covered medications purchased through the Plan's retail pharmacy network or mail service pharmacy.
- We added a preauthorization requirement for high-end radiology procedures (MRI, CT and PET scans) in Section 5(a), Lab, X-ray and other diagnostic tests.
- We added coverage details for the rental or purchase of breastfeeding equipment in Section 5(a), Maternity care.
- We added coverage for outpatient care in an urgent care facility for a medical emergency under Section 5(a), Diagnostic and treatment services.
- We added coverage for the services provided by a Licensed Social Worker (LSW) under Section 5(a), Home health services.
- We added a prior approval requirement for all specialty drugs. See Section 5(f), Prescription drug benefits.
- We expanded the list of covered transplants in Section 5(b), Organ/tissue transplants.
- We have combined the ancillary and room and board copayments for In-network and Out-of-network hospital stays under Section 5(c), Inpatient hospital.
- We added coverage for ambulance services when transport is not required. See Sections 5(c) and (d), Ambulance.
- We removed the deductible on In-network and Out-of-network ambulance services. Se Sections 5(c) and (d), Ambulance.
- We added a Tier IV prescription drug copayment of $80 for Network Mail Service Specialty Drugs.
- We added Habilitative care coverage under Section 5(a) Physical, occupational and speech therapies.

Section 3. How you get care

Identification cards

We will send you and each covered family member 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, 2nd Floor, Alexandria, VA 22314-3466.

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 our provider 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 the states OPM determines are "medically underserved". For 2014 the states are: Alabama, Arizona, Idaho, Illinois, Louisiana, Mississippi, Missouri, New Mexico, North Dakota, Oklahoma, South Carolina and Wyoming.

Provider Non-Discrimination: In compliance with the Public Health Service Act, we cover any licensed medical practitioner for any covered service performed within the scope of that provider's state issued license or certification.

- **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:

- 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
- 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 or the Commission on Accreditation of Rehabilitation Facilities (CARF).

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 network specialist because we terminate our contract with your specialist for reasons other than for cause,

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

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

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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-638-8432. If you are new to the FEHB Program, we will reimburse you for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

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

You need prior Plan approval for certain services

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

- **Inpatient hospital admission**

Precertification is the process by which we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition prior to your inpatient hospital admission or residential treatment care. 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 your care is precertified, you should always ask your physician or hospital whether they have contacted us.

Warning: We will reduce our benefits for the inpatient hospital stay 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.

Exceptions You do not need precertification in these cases:

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

- **Other services** Some services require a referral, precertification, or prior authorization. Please call 1-800-638-8432 for approval for:
  - Home health care (see Section 5(a))
  - High-end radiology scans (see Section 5(a))
  - Organ/Tissue transplants (see Section 5(b))
  - Skilled nursing care (see Section 5(c))
  - Mental health and substance abuse treatment (see Section 5(e))

How to request precertification for an admission or get prior authorization for Other services

First, you, your representative, your physician, or your hospital must call us at 1-800-638-8432 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- Enrollee's name and Plan identification number;
- Patient's name, birth date, identification number and phone number;
- Reason for hospitalization, proposed treatment, or surgery;
- Name and phone number of admitting physician;
- Name of hospital or facility; and
- Number of planned days of the hospital stay.

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

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

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

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

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-800-638-8432. You may also call OPM's Health Insurance 2 at 1-202-606-3818 between 8 AM and 5 PM Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-800-638-8432. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital. If you do not telephone the Plan within two business days, penalties may apply - see *Warning* under *Inpatient hospital admission* earlier in this Section and *If your hospital stay needs to be extended* below.

- **Maternity care**

You do not need precertification of 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. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then

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

- **If your treatment needs to be extended**

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

If you disagree with our pre-service claim decision

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

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

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

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

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

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

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

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

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your costs for covered services

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

Cost-sharing

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

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services.

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

Note: If the billed amount or the Plan allowance that providers we contract with have agreed to accept as payment in full is less than your copayment, you pay the lower amount.

Deductible

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

- The calendar year deductible for In-network services is $350 per person and for Out-of-network 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 In-network services and $800 for Out-of-network 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 a separate deductible for dental care of $50 per person each calendar year.

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible.

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

If your provider routinely waives your cost

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

For example, if your physician ordinarily charges $100 for a service but routinely waives your 25% coinsurance, the actual charge is $75. We will pay $56.25 (75% of the actual charge of $75).

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health Plan. If you sign such a waiver, whether you are responsible for the total charge depends on the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 1-800-638-8432.

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 network area, you should use an In-network provider whenever possible. The following two examples explain how we will handle your bill when you go to a In-network provider and when you go to a Out-of-network provider. When you use an In-network provider, the amount that you pay will usually be much less.

- **In-network providers** agree to limit what they will bill you. Because of that, when you use a network provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see an In-network 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 In-network physician will not bill you for the $50 difference between our allowance and his/her bill.

Follow these procedures when you use an In-network provider to receive In-network benefits:

- Verify with us that your home address is correct
- When you make an appointment, verify that the physician or facility is still a network provider
- Present your Rural Carrier Benefit Plan ID card at the time that you receive services to receive In-network benefits
- Do not pay a network provider at the time that you receive services, except for any copayment or deductible that you owe. Network providers will bill us directly and we will pay them. The network provider will then bill you for any balance due after we pay them.
- **Out-of-network providers**, on the other hand, have no agreement to limit what they will bill you. When you use an Out-of-Network 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 out-of-network 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 out-of-network physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.

Participating providers agree to limit what they can collect from you. You will still have to pay your deductible and coinsurance. These providers agree to write off the difference between billed charges and the discount amount.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a network physician vs. an out-of-network 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	**Network physician**	**Out-of-network 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 copayments, coinsurance or deductibles apply, we pay 100% of the Plan allowance for the rest of the calendar year after your expenses total to:

- $4,000 per person or $4,500 per family when you use In-network providers/facilities, or
- $4,500 per person or $5,000 per family when you use In-network and Out-of-network providers/facilities combined
- $4,000 per person or $4,500 per family when you use a CVS Caremark network or non-network retail and /or mail service pharmacy

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

- Expenses for dental care
- Expenses in excess of our allowances or maximum benefit limits
- 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
- 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.

If we overpay you

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

When Government facilities bill us

Facilities of the Department of 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. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 15 for how our benefits changed this year. Pages 96-97 are a benefits summary of 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 In-network services and $400 per person for Out-of-network services ($700 per family for In-network services and $800 per family for Out-of-network 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 Out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use a network provider. When no network provider is available, Out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

Benefit Description	You Pay
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 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).	In-network: $20 copayment (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
• Outpatient care in an urgent care facility because of a medical emergency Note: we pay medical supplies, medical equipment, prosthetic and orthopedic devices for use at home under Section 5(a), *Medical services and supplies.*	In-network: $35 copayment (No deductible) Out-of-network:15% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians (except 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	In-network: 15% of the Plan allowance Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay
Diagnostic and treatment services (cont.)	
Note: We cover contraceptive drugs under Prescription Drug Benefits, Section 5(f).	In-network: 15% of the Plan allowance Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Professional non-emergency services provided in a convenient care clinic (see Definitions, Section 10) Note: For services related to an accidental injury or medical emergency, see Section 5(d)	In-network: $10 copayment per visit (No deductible) Out-of-network: 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	
Tests, such as: • Blood tests • Lab tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • CT scans, MRI scans, PET scans Note: Preauthorization is required for all High End Radiology procedures, such as but not limited to, CT scans, MRI scans, and PET scans except in the case of an accident or medical emergency. See Section 3, Other services. • Ultrasound • Electrocardiogram and EEG • Sonograms • Hearing test (when medically necessary) Note: Urine drug testing/screening is covered only as described in "FEHBP Urine Drug Testing Coverage", available on our Website, http://rcbp.coventryhealthcare.com, or by calling us at 1-800-638-8432.	In-network: 15% of Plan allowance Note: If your physician uses the Quest Diagnostics/LabOne to test your specimen, you will pay nothing for the lab test (No deductible). See Special features, Section 5(h) for additional information. Note: If you or your physician voluntarily uses US Imaging to coordinate your diagnostic imaging test (CT scan, MRI scan or PET scan) , you will pay nothing for the scan (No deductible or coinsurance). See Special features, Section 5(h) for additional information. **This benefit is not available when Medicare is the primary payor or when a Plan member is eligible for Medicare coverage.** Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount. Note: If your network provider uses an out-of-network lab or radiologist, we will pay out-of-network benefits for any lab and X-ray charges. Note: For genetic testing for prescription drugs see Section 5(h), Special features.
Preventive care, adult	
A routine physical exam – one per person each calendar year to include patient history and risk assessment, basic metabolic panel and general health panel, urinalysis, biometric screenings and routine X-rays as recommended preventive services under the Patient Protection and Affordable Care Act.	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
Note: Lab tests and X-rays are covered under Lab, X-ray and other diagnostic tests, Section 5(a), unless coded as routine.	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Routine screenings, such as: • Blood cholesterol and/or lipid panel/profile--one per person each calendar year • Chlamydial infection • Osteoporosis screening -- every year starting at age 50 • Abdominal aortic aneurysm screening (limited to one per lifetime), for males ages 65 to 75 who have ever smoked • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening – every five years starting at age 50 - Colonoscopy -- every 10 years starting at age 50	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Prostate Specific Antigen (PSA) test -- every year for men starting at age 40	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Well woman care, including, but not limited to: • Routine pap test, starting at age 18 • Human papillomavirus testing • Annual counseling for sexual transmitted infections • Annual counseling and screening for human immune-deficiency virus (HIV) • Screening and counseling for interpersonal and domestic violence Note: If you see another physician for your pap smear, the office visit will be covered.	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Routine mammogram -- every year for women starting at age 35	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Zostavax (shingles) vaccine, no age limit • Human Papillomavirus (HPV) vaccine for cervical cancer, no age limit • Adacel vaccine (adult booster for tetanus, diphtheria and pertussis) • Influenza vaccine	In-network: Nothing (No deductible) Out-of-network: Nothing up to the Plan allowance then any difference between our allowance and the billed amount (No deductible)

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
• Pneumococcal vaccine	In-network: Nothing (No deductible) Out-of-network: Nothing up to the Plan allowance then any difference between our allowance and the billed amount (No deductible)
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.cdc.gov/nccdphp/dnpao/hwi/resources/preventative_screening.htm	
Preventive care, children	
• Well child visits • Childhood immunizations recommended by the American Academy of Pediatrics for dependent children under age 22. • Rotavirus vaccine for infants less than 1 year old • Retinal screening exam performed by an ophthalmologist for infants with low birth weight, less than 1 year of age and with an unstable clinical course • Hearing screening exam testing and diagnosis and treatment (including hearing aids) for hearing loss • Body Mass Index (BMI) Testing for children under age 22	In-network: Nothing (No deductible) Out-of-network: Nothing up to Plan allowance then the difference between our allowance and the billed amount (No deductible)
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www2.aap.org/immunization/pediatricians/pediatricians.html /.	
Maternity care	
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk • Prenatal care (including laboratory tests) • Delivery • Postpartum care • Sonograms • Emergency room and specialty visits for pregnancy complications	In-network: Nothing (No deductible) Out-of-network: 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.
• Breastfeeding support and counseling for each birth • Breastfeeding equipment rental or purchase	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	
Note: We limit our benefit for the rental of breastfeeding equipment to an amount no greater than what we would have paid if the equipment is purchased. We will only cover the cost of standard equipment. Note: When standard breastfeeding equipment is purchased at a CVS Pharmacy, you pay nothing (No deductible).	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 12 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. Surgical benefits, not maternity benefits, apply to circumcision. • We cover the initial routine examination of your newborn infant covered under your family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	
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	
Contraceptive counseling on an annual basis	In-network: Nothing Out-of-network: Nothing
A range of voluntary family planning services, including patient education and counseling, limited to: • Voluntary sterilization (See Section 5(b), Surgical procedures) • Injection of contraceptive drugs (such as Depo-Provera)	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

Family Planning - continued on next page

Benefit Description	You Pay
Family Planning (cont.)	
• FDA-approved birth control drugs and devices requiring a physician's written prescription Note: We cover oral contraceptive drugs, diaphragms, cervical caps, vaginal rings and contraceptive hormone patches. See Section 5(f), Prescription drug benefits. Note: Surgically implanted, fitting, insertion or removal of contraceptive devices is covered under Surgical Services, Section 5(b).	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling, testing or screening*	*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	In-network: 15% of the Plan allowance Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination* - *In vitro fertilization* - *Embryo transfer and gamete intrafallopian transfer (GIFT)* - *Zygote intrafallopian transfer (ZIFT)* - *Intracytoplasmic sperm injection (ICSI)* - *Intravaginal insemination (IVI)* - *Intracervical insemination (ICI)* - *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures* • *Infertility drugs used in conjunction with ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Benefit Description	You Pay
Allergy care	
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	In-network: Services in a physician's office --$20 copayment (No deductible) Services outside the physician's office—15% of the Plan allowance Out-of-network: 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 network provider.
Not covered: • *Food tests* • *RAST 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 pages 43-47. • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Human Growth Hormone therapy (HGHT) • Respiratory and inhalation therapies Note: Drugs used in treatment therapies are covered under Prescription drug benefits in Section 5(f).	In-network: 15% of the Plan allowance Out-of-network: 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 - Occupational therapists Note: We provide physical, occupational and speech therapy for those diagnosed with Autism. Note: Inpatient physical, occupational and speech therapies are covered under Section 5(c).	In-network: 15% of the Plan allowance Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

Physical and occupational and speech therapies - continued on next page

Benefit Description	You Pay
Physical and occupational and speech therapies (cont.)	
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Routine hearing exam, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	In-network: Nothing (No deductible) Out-of-network: Nothing (No deductible)
Hearing aids for adults • One hearing aid per ear and related services, including implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	In-network: Nothing up to $1,200 per ear, then all charges (no deductible) Out-of-network: Nothing up to $1,200 per ear, then all charges (no deductible) Note: This benefit is available once every five years.
Not covered: • *Hearing aids and related expenses, except as noted above*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses with standard frames or contact lenses (including fitting) 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(h), for our benefit for routine eye examinations, including eye refractions.	In-network: 15% of the Plan allowance Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses , except as shown above* • *Deluxe lens features for eyeglasses or contact lenses such as special coatings, polarization, UV treatment, and multifocal, accommodating, toric or other premium intraocular lenses (IOLs), including Crystalens, ReStorm and ReZoom* • *Eye exercises and orthoptics* • *Refractive eye surgery and related expenses*	*All charges*

Benefit Description	You Pay
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 15% of Plan allowance Out-of-network: 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, except as stated above* • *Orthopedic shoes and other devices to support the feet, except as shown in Section 5(a) Orthopedic and prosthetic devices*	*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 and surgically implanted breast implant following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device and Section 5(c) for services provided by a hospital.	In-network: 15% of the Plan allowance Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Hearing aids for adults • One hearing aid per ear and related services, including implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants	In-network: Nothing up to $1,200 per ear, then all charges (No deductible) Out-of-network: Nothing up to $1,200 per ear, then all charges (No deductible) Note: This benefit is available once every five years.
Foot orthotics • Prescribed by a physician • Custom fitted, including necessary repair and adjustment • Impression casting • Corrective shoes to treat malformation and weakness of the foot	In-network: Nothing up to $250 per foot, then all charges (No deductible) Out-of-network: Nothing up to $250 per foot, then all charges (No deductible) Note: This benefit is available for one replacement every three years
Not covered: • *Orthopedic and corrective shoes and other supportive devices for the feet* • *Arch supports* • *Foot orthotics, except as described above* • *Heel pads and heel cups* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices, unless we determine their medical necessity*	*All charges*

Benefit Description	You Pay
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; • Have a therapeutic purpose in the treatment of an illness or injury We cover rental, up to the purchase price, or purchase (at our option), including necessary repair and adjustment, of durable medical equipment, such as: • Oxygen • Dialysis equipment • Hospital beds • 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) • Seat lift mechanism on a lift chair provided that all of the following criteria are met: - The patient has severe arthritis of the hip or knee or a severe neuromuscular disease - The seat lift mechanism is part of a physician's treatment plan and is prescribed to improve the patient's condition or stop or delay deterioration in the patient's condition - The patient is incapable from standing up from a any chair in the home - After standing, the patient must be able to walk Note: Coverage is limited to the seat lift mechanism only, even if the mechanism is part of a chair.	In-network: 15% of the Plan allowance Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Augmentative and alternative communications (AAC) devices such as: • Computer story boards • Light talkers • Enhanced vision systems • Speech aid prosthesis for pediatrics	In-network: Nothing up to a maximum of $1,000 per device per calendar year (No deductible) Out-of-network: Nothing up to a maximum of $1,000 per device per calendar year (No deductible) Note: Limited to one device per person per calendar year

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	
• Speech aid prosthesis for adults • Magnifier Viewing System • Script Talk reader devices	In-network: Nothing up to a maximum of $1,000 per device per calendar year (No deductible) Out-of-network: Nothing up to a maximum of $1,000 per device per calendar year (No deductible) Note: Limited to one device per person per calendar year
Not covered: • *Sun or heat lamps, whirlpool bath, heating pads, air purifiers, humidifiers, air conditioners and exercise devices* • *Charges for service contracts for purchased or rented equipment, except for purchased oxygen concentrators* • *Equipment replacement provided less than three years after the last covered one unless defective or damaged beyond repair*	*All charges*
Home health services	
If home health services are preauthorized, we pay for up to 90 visits per person per calendar year when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services ; and • The physician indicates the length of time the services are needed. Note: Services provided by a licensed social worker (L.S.W.) are limited to 2 visits per calendar year and will count toward the visit maximum above.	In-network: 15% of the Plan allowance (No deductible). You pay all charges after 90 visits per calendar year. Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount (No deductible). You pay all charges after 90 visits per calendar year.
If home health services are not preauthorized, we will pay for up to 40 visits per calendar year. Note: All visits for home health care services, whether preauthorized or not, are combined and cannot exceed 90 visits per calendar year. Note: Services provided by a licensed social worker (L.S.W.) are limited to 2 visits per calendar year and will count toward the visit maximum above. 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)	In-network: 15% of the Plan allowance (No deductible). You pay all charges after 40 visits per calendar year. Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount (No deductible). You pay all charges after 40 visits per calendar year.
Not covered:	*All charges*

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	
• *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	In-network: $20 copayment per visit (No deductible) Out-of-network: 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.	In-network: 15% of the Plan allowance for up to 30 visits per person each calendar year (No deductible). After 30 visits, you pay all charges. Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount for up to 30 visits per person each calendar year (No deductible). After 30 visits, you pay all charges.
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	
Tobacco cessation program • Counseling sessions are provided through only the Free & Clear smoking cessation program. See Special features, Section 5(h) • Physician prescribed over-the-counter (OTC) and prescription drugs for smoking cessation are available through the Free & Clear smoking cessation program. See Special features, Section 5 (h) Note: For additional information on the Free & Clear smoking cessation program, see Special features, Section 5(h).	In-network: Nothing (No deductible) for counseling and physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence Out-of-network: Nothing (No deductible) for counseling and physician prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence Note: Counseling and approved drugs for smoking cessation may be received through the Free & Clear program. See Section 5(h), Special features.
Diabetic education • One diabetic education and training program per person each calendar year.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Nutritional counseling	In-network: 15% of the Plan allowance (No deductible)

Educational classes and programs - continued on next page

Benefit Description	You Pay
Educational classes and programs (cont.)	
Note: We cover the services of a dietician, nutritionist and diabetic educators who bill independently for nutritional counseling. Note: Nutritional counseling and diabetes care education or training have a separate Plan benefit.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any differnce between our allowance and the billed amount (No deductible)
Weight management program Coverage is limited to: • A non-surgical outpatient treatment program when diagnosed by a physician if the patient has a Body Mass Index (BMI) of 30 or higher. Benefits will be payable for the following medically necessary services: - Initial evaluation by your physician - Follow-up visits to your physician - Individual or group behavioral counseling - Initial and follow-up lab tests - Maintenance counseling and follow-up visits for maintenance Note: The cost for prescription drugs for weight loss and/or maintenance are covered as shown under Section 5(f), Prescription drug benefits. The cost of prescription drugs is not applied to the maximum annual weight management program limit.	In-network: Nothing up to $1,000 per program per person per calendar year, and then all charges (No deductible) Out-of-network: Nothing up to $1,000 per program per person per calendar year, and then all charges (No deductible)
Not covered: • *Body composition analysis* • *Nutritional supplements or food* • *Non-prescription drugs or supplies* • *Exercise or weight loss programs and exercise equipment* • *Services that are not medically necessary*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $350 for In-network services and $400 per person for Out-of-network services ($700 per family for In-network services and $800 per family for Out-of-network 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 Out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use a network provider. When no network provider is available, Out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- 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 FOR INPATIENT SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay After the calendar year deductible…
Surgical procedures	
A comprehensive range of services, such as: • Surgical procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Voluntary male sterilization (e.g., vasectomy) • Circumcision • Treatment of burns	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Surgical procedures (cont.)	
Surgical treatment of morbid obesity (Bariatric surgery)-- a condition in which a person (1) has a Body Mass Index (BMI) equal to or greater than 40 or a BMI equal to or greater than 35 with other illnesses such as hypertension, heart disease, diabetes, sleep apnea, or hyperlipidemia which has existed for at least five years, and; (2) is age 18 or older; and (3) has been under at least one physician supervised weight loss program, including diet and nutrition counseling, exercise and behavior modification, that is at least six months in length. Insertion of internal prosthetic devices . See Section 5 (a), Orthopedic and prosthetic devices for device coverage information	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
• Voluntary female sterilization (e.g., tubal ligation) • Surgically implanted contraceptives • Intrauterine devices (IUDs) Note: For related and necessary services to voluntary sterilization, such as anesthesia and outpatient facility charges, we cover 100% of the Plan allowance for In-network care.	In-network: Nothing (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
When multiple or bilateral surgical procedures are performed during the same operative session by the same surgeon, our benefits are: • For the primary procedure: the Plan's allowance • For the secondary procedure and any other subsequent procedures: one-half of the Plan allowance (unless the network contract provides for a different amount) 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.	In-network: 10% of the Plan allowance for the primary procedure (No deductible) Out-of-network: 25% of the Plan allowance for the individual procedure and any difference between our allowance and the billed amount
Co-surgeons When the surgery requires two surgeons with different skills to perform the surgery, the Plan’s allowance for each surgeon is 62.5% of what it would allow a single surgeon for the same procedure(s), unless the network contract provides for a different amount.	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Assistant Surgeons	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Surgical procedures (cont.)	
Assistant surgical services provided by a surgeon (M.D. or D.O.) when medically necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan's allowance for the assistant surgeon is 16% of the allowance for the surgery (unless the network contract provides for a different amount). Note: A Physician Assistant (P.A.) is a covered provider. Other non-physician providers such as, but not limited to, a Certified Registered Nurse First Assistant (C.R.N.F.A.) and a Certified Surgical Technologist (C.S.T.) are not covered.	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
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	
• 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 of breasts; - treatment of any physical complications, such as lymphoedema; - breast prostheses; and surgical bras and replacements (see *Prosthetic devices,* Section 5 (a) for coverage)	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Reconstructive surgery (cont.)	
Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury 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, including anesthesia • Excision of cysts and incision of abscesses when done as independent procedures • Dental surgical biopsy • Surgical correction of temporomandibular joint (TMJ) dysfunction • Frenectomy and frenotomy not as a result of orthodontic care	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants and related services* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are covered. These solid organ transplants are subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Solid organ transplants limited to: • Cornea • Heart	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description. • **Allogeneic transplants for:** - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/ lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL)	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • **Autologous transplants for**: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Advanced childhood kidney cancers - Advanced Ewing sarcoma - Amyloidosis - Breast cancer - Childhood rhabdomyosarcoma - Epithelial ovarian cancer - Mantle cell (Non-Hodgkin's lymphoma) - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Mini-transplants performed in a clinical trial setting (non-myeloblative reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • **Allogeneic transplants for:** - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • **Autologous transplants for**: - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • Autologous transplants for: - Advanced Ewing sarcoma - Advanced Childhood kidney cancers - Breast cancer - Childhood rhabdomyosarcoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma)	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
Note: All allowable charges incurred for a surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury subject to the limits stated above. This benefit applies only if we cover the recipient and if the donor's expenses are not otherwise covered. Note: We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to testing of family members. Note: Coventry Health Care has special arrangements with transplant facilities to provide services for tissue and organ transplants. The Coventry Transplant Network is designed to give you the opportunity to access providers that demonstrate high quality medical care for transplant patients. Your physician can coordinate arrangements by calling Coventry Health Care at 1-800-638-8432.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Physician's office Note: We follow the Center for Medicare and Medicaid Services (CMS) guidelines for the determination of the Plan allowance for professional services for the administration of anesthesia.	In-network: 10% of the Plan allowance (No deductible) Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- In this Section, unlike Sections 5(a) and 5(b), the calendar year deductible applies to only a few benefits. We added "(calendar year deductible applies)". The calendar year deductible is: $350 per person ($700 per family) for In-network services and $400 per person ($800 per family) for Out-of-network services. The Out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use a network provider. When no network provider is available, Out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- 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).
- When you use a network facility, keep in mind that the health care professionals who provide services to you in the facility may not be network providers in our provider network. However, if the services are received at a network facility, we will pay up to the Plan allowance at the network provider reimbursement level for services you receive from an Out-of-network radiologist, anesthesiologist (including a Certified Registered Nurse Anesthetist (CRNA)), emergency room physician, surgeon, neonatologist and pathologist when immediate or emergency treatment is required. You will be responsible for the difference between our benefit payment and the billed amount.
- **YOU MUST GET PRECERTIFICATION FOR HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Note: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations • 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.	In-network: $100 copayment for each hospital stay (copayment waived for a maternity stay) Out-of-network: $300 copayment for each hospital stay and 25% of the covered charges

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
Note: An overnight stay in a hospital does not always mean you are admitted as an inpatient. You are considered an inpatient the day your physician formally admits you to a hospital with a doctor's order. Whether you are an inpatient or outpatient affects your out-of-pocket expenses. Always ask if you are an inpatient or outpatient at the hospital. 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: Colostomy and ostomy supplies are covered under Section 5(a), Durable medical equipment. Note: Take-home prescription drugs and medicines 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.	In-network: $100 copayment for each hospital stay (copayment waived for a maternity stay) Out-of-network: $300 copayment for each hospital stay and 25% of the covered charges
Not covered: • *Any part of a hospital admission that is not medically necessary(see definition in Section 10), 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 in Section 10) even when provided in a hospital* • *Non-covered facilities, such as nursing homes, rest homes, convalescent homes, facilities for the aged, and schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
• *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	
• 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: Colostomy and ostomy supplies are covered under Section 5(a), Durable medical equipment. Note: Take-home prescription drugs and medicines 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.	In-network: 15% of the Plan allowance (calendar year deductible applies) Out-of-network: 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 preauthorized, we cover semiprivate room, 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 supervised by a physician	In-network: Charges in excess of the 60-day maximum Out-of-network: Charges in excess of the 60-day maximum and the difference between the Plan allowance and the billed amount

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You Pay
Extended care benefits/Skilled nursing care facility benefits (cont.)	
Note: If Medicare pays first for your care, the first 20 days of your stay (paid in full by Medicare) count toward the 60-day benefit limit each calendar year.	In-network: Charges in excess of the 60-day maximum Out-of-network: Charges in excess of the 60-day maximum and the difference between the Plan allowance and the billed amount
If care is not preauthorized, we cover semiprivate room and board services and supplies for up to 30 days per calendar year, subject to the above conditions. Note: Days preauthorized and not preauthorized are combined and cannot exceed 60 days in a calendar year.	In-network: 20% for the first 30 days, then all charges Out-of-network: 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. Note: This benefit does not apply to services covered under any other benefit of the Plan.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Private duty nursing* • *Custodial care*	*All charges*
Ambulance	
• Professional ambulance service to the nearest facility equipped to handle the patient's condition, including air ambulance when medically necessary. Note: We also cover medically necessary emergency care provided at the scene when transport services are not required. Note: See Section 5(d) for emergency ambulance service.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
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 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 In-network services and $400 per person for Out-of-network services ($700 per family for In-network services and $800 per family for Out-of-network 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 Out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use a network provider. When no network provider is available, Out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

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(g).

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	
If you or a family member is accidentally injured, the Plan will pay up to the Plan allowance for: • Covered services and supplies provided in an initial emergency room facility visit for an accidental injury; or • Covered services and supplies provided in an initial urgent care center visit for an accidental injury; or • Covered services and supplies provided during the initial visit to a physician's office for an accidental injury, including related services outside the physician's office. Services must be provided the same day as the initial office visit. We pay for services performed after the initial visit, such as x-rays, laboratory tests, drugs, or any supplies or other services under Section 5(a). Note: We pay Hospital benefits if you are admitted.	In-network: Nothing (No deductible) Out-of-network: The difference between the Plan allowance and the billed amount (No deductible)

Benefit Description	You pay After the calendar year deductible…
Medical emergency	
Plan benefits are paid for care you receive because of a medical emergency (non-accident) like a heart attack or stroke, including anesthesia.	In-network: **Services in a physician's office--**$20 copayment (No deductible) **Services outside the physician's office—**15% of the Plan allowance Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Services you receive for your medical emergency in an urgent care center. Note: We pay medical supplies, medical equipment, prosthetic and orthopedic devices for use at home under Section 5(a), *Medical services and supplies.*	In-network: $35 copayment per occurrence (No deductible) Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Ambulance	
• Professional ambulance service to the nearest facility equipped to handle the patient's condition, including air ambulance when medically necessary. Note: We also cover medically necessary emergency care provided at the scene when transport services are not required. Note: See 5(c) for non-emergency service.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Ambulance transport for your own or your family's convenience* • *Ambulance transportation from the hospital to home*	*All charges*

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

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

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 or, for facility care, the inpatient copayment applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- 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 FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan:
- Precertification to establish the medical necessity of your stay in a hospital, residential treatment center or other facility. Please see page 18 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 pages 18-21 for information on how to preauthorize your care.
- Review of continuing treatment to establish the medical necessity of your continuing treatment for all levels of outpatient or office care. Please see page 20, for information on how to get review of continuing treatment.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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.

Benefit Description	You Pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional services	
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-network: **Services in a physician's office**--$20 copayment (No deductible) **Services outside the physician's office**--15% of the Plan allowance Out-of-network: 25% of the Plan allowance and any difference between our allowance and the billed amount
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	In-network: 15% of the Plan allowance Out-of-network: 25% of the Plan allowance any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-network: $100 copayment for each inpatient stay (No deductible) Out-of-network: $300 copayment for each inpatient stay and 25% of the covered charges (no deductible)
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment - Partial hospitalization includes a time-limited, ambulatory, active treatment program that: - Offers intensive clinical services that are coordinated and structured in stable surroundings; and	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Outpatient hospital or other covered facility - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Outpatient hospital or other covered facility (cont.)	
- 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	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
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 marital, educational, sexual paraphilias, behavioral diagnoses, or related to mental retardation and learning disorders* • *Community based programs such as self-help groups or 12-step programs* • *Applied Behavior Analysis (ABA)*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the page 59.
- 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 prescription drug deductible is: $200 per person . 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 Out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use a network provider. When no network provider is available, out-of-network benefits apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION FOR CERTAIN DRUGS.**

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 the prescription at a CVS Caremark participating pharmacy, a non-network pharmacy, or through the CVS Caremark mail service prescription program for a maintenance medication.

- **CVS Caremark participating pharmacy:** You may fill your prescription at any CVS Caremark participating pharmacy. To find a participating pharmacy near where you live, call CVS Caremark toll-free at 1-800-831-4440 or on the Internet at www.Caremark.com or through a link on our Website at www.nrlca.org. **You must show the pharmacy your Plan ID card (that includes the CVS Caremark logo) or a 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 CVS Caremark participating pharmacy and show your Plan ID card or the Caremark prescription drug card. The participating pharmacy will file the claim with CVS Caremark for you. **Prescriptions you purchase at a CVS Caremark network pharmacy without using your ID card or a Caremark prescription drug card are at the full regular price charged by the pharmacy. If you do not show your ID card or Caremark prescription drug card at a participating pharmacy, you will need to file a claim with CVS 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 CVS Caremark.
- **CVS Caremark mail service pharmacy:** You may fill your long-term prescription through the CVS Caremark mail service pharmacy. You will receive order forms and information on how to use the mail service prescription program from CVS Caremark. To order your prescription by mail: 1) complete the CVS Caremark order form; 2) enclose your prescription(s) and copayment(s); 3) mail your order to CVS 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 service program. You can also order refills from the mail service program by telephone toll-free at 1-800-831-4440 or on the Internet at www.Caremark.com

CVS Caremark's Primary/Preferred Drug list

The CVS Caremark Primary/Preferred Drug list is a list of "preferred" prescription drugs that are identified by the CVS Caremark team of physicians and pharmacists (Pharmacy and Therapeutics Committee) to be the best overall value based on quality, safety, effectiveness, and cost. The Primary/Preferred Drug list includes nearly all covered generic drugs, and specific brand-name drugs. We list the most commonly requested formulary drugs on the Primary/Preferred Drug list. To order a Primary/Preferred Drug list, call the CVS Caremark Customer Service Department at 1-800-831-4440 or visit our Website at www.nrlca.org and click on Insurance.

We also cover non-preferred (non-formulary) drugs prescribed by your Plan physician. However, we encourage you to use preferred drugs, especially preferred generic drugs, whenever possible because they will cost you less. Refer to the Primary/Preferred Drug list and check with your physician or pharmacist to find out if a preferred generic drug is available, or if a lower-cost alternative might work for you.

- **Prior Authorization**. We require prior authorization for certain drugs. To obtain a list of drugs that require prior authorization, please call the CVS Caremark Customer Service Department at 1-800-831-4440. The prior authorization drug list is reviewed by the CVS Caremark Pharmacy and Therapeutics Committee and may change from time to time due to new drugs, new generic drugs, new therapies, new guidelines from the Food and Drug Administration (FDA), or other factors. For those drugs that require prior authorization, you should discuss with your physician or pharmacist about available options that do not require prior authorization. To request prior authorization, your physician may contact the CVS Caremark Prior Authorization Department at 1-855-240-0536. CVS Caremark will work with your physician to obtain the information we need to process the request. You may contact our Customer Service Department for the status of your request.

Specialty drugs are unique prescription medicines that are often high-cost injectable, infused, oral or inhaled drugs that require close supervision and monitoring by your pharmacy. You must purchase certain specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs through the CVS Caremark Specialty Pharmacy Services.

All specialty drugs require prior approval to ensure appropriate treatment therapies for chronic complex conditions. Call CVS Caremark Specialty Pharmacy Services at 1-866-814-5506 to obtain prior approval. Decisions about prior approval are based on guidelines developed by physicians at the FDA or independent expert panels and are administered by the CVS Caremark Specialty Pharmacy's clinical team.

These are the dispensing limitations.

- You may purchase up to a 34-day supply of medication at any network retail pharmacy. There is a limit an the number of refills that you can buy at a network retail 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 medications at a network retail pharmacy during any twelve month period. After the second fill at a network retail pharmacy, you must purchase your long-term medications through the CVS Caremark Mail Service pharmacy or a CVS Pharmacy to have the prescriptions 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 CVS Caremark for reimbursement after you satisfy the annual $200 prescription drug deductible (see page 49).
- A generic equivalent will be dispensed if it is available. If you receive a prescription for a name brand drug when a Federally-approved generic drug is available, even if your physician requests "Dispense as Written" (DAW) on the prescription, you have to pay the difference in cost between the name brand drug and its generic equivalent plus the brand name (Tier III) copayment.
- You may purchase up to a 90-day supply of a medication through the CVS Caremark mail service 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), CVS Caremark will return the refill request to you. CVS 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, CVS Caremark will substitute for a brand name drug. Certain types of prescription medications are not available through the mail service program such as:
  - Specially mixed (compounded) capsules and suppositories

- Vaccines
- Frozen medications
- Dental products
- Most medical devices
- Infertility drugs
- Medications specially wrapped in unit dose packaging

Note: Always request a generic drug from your physician or other prescriber when a generic is available. If a generic equivalent is available, but the pharmacy dispenses the brand name medication, you will pay the difference in cost between the brand name medication and the generic medication plus the brand name (Tier III) copayment. Similarly if your physician or other prescriber indicates "dispense as written" on the prescription, you will pay the difference in cost between the brand name medication and the generic medication plus the brand name (Tier III) copayment.

CVS 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.

- If you have Medicare Part B, we do not waive your deductible or coinsurance for prescription drugs and supplies that you buy at a CVS Caremark participating pharmacy or at a non-participating pharmacy. However, your copayment is reduced for 90-day prescriptions that you order through the CVS Caremark mail service prescription program or at a CVS retail pharmacy.

Note: We waive your deductible and coinsurance at a network retail pharmacy and the copayment at the CVS Caremark mail service pharmacy if Medicare Part B covers your prescription drugs or diabetic supplies and is the primary payor. See Section 9 for further information.

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 CVS 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 CVS Caremark. Use the CVS Caremark prescription claim form and send your claim to:

CVS Caremark
P O Box 52196
Phoenix AZ 85072-2196

Claims for prescription drugs and supplies that are not ordered through the CVS Caremark mail service 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 1-800-831-4440 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 service order form/patient profile and a preaddressed reply envelope for the mail service prescription program. You may purchase the following medications and supplies prescribed by a physician from either a retail pharmacy or through the Mail Service Pharmacy: • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that require a physician's written prescription by Federal law of the United States, except those listed as *Not covered.* • Prescription pre-natal vitamins • Prescription vitamins after Bariatric surgery • Insulin and diabetic supplies such as test strips, lancets, etc. • Needles and syringes for the administration of covered medications • Colostomy and ostomy supplies (Network and Out-of-Network Retail only)	• Network Retail: 30% of cost • Network Retail when retired with Medicare Part B coverage: 30% of cost • Out-of-Network Retail: 30% of cost • Out-of-Network Retail when retired with Medicare Part B coverage: 30% of cost • Network Mail Service: - Tier I: $10 generic (No deductible) - Tier II: $30 brand name on primary drug list (No deductible) - Tier III: $47 brand name not on primary drug list (No deductible) - Tier IV: $80 specialty drugs (no deductible) • Network Mail Service when retired with Medicare Part B coverage: - Tier I: $10 generic (No deductible) - Tier II: $20 brand name on primary drug list (No deductible) - Tier III: $37 brand name not on primary drug list (No deductible) - Tier IV: $80 specialty drugs (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 (network) pharmacy or at a non-participating (out-of-network) pharmacy. You must use the Mail Service pharmacy or a CVS Pharmacy for a continuing supply of the medication after three fills. Note: For long-term maintenance medications (90-day supply) purchased at a CVS Pharmacy, you pay the same copayments (No deductible) as the Network Mail Service Pharmacy.
Women's contraceptive drugs and devices, including: • FDA-approved oral contraceptives that require a written prescription including the over-the-counter (OTC) emergency contraceptive drug • Diaphragms • Cervical caps • Vaginal rings • Contraceptive hormone patches	Network Retail: Nothing (No deductible) Out-of-Network Retail: 30% of cost (No deductible) Network Mail Service: Nothing (No deductible)
Medicines to promote better health recommended under the Patient Protection and Affordable Care Act (the Affordable Care Act), limited to:	Network Retail: Nothing Out-of-Network Retail: All charges

Covered medications and supplies - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Covered medications and supplies (cont.)	
• Iron supplements for children age 6 months through 12 months • Oral flouride supplements for children age 6 months through age 5 • Folic acid supplements (0.4 to 0.8 mg) for women of child bearing age • Aspirin for men ages 45 through 79 and women ages 55 through 79 • Vitamin D for adults age 65 and older Note: To receive this benefit, you must use a network retail pharmacy and present a physician's written prescription to the pharmacist. Note: Benefits not available for Tylenol, Ibuprofen, Aleve, etc.	Network Retail: Nothing Out-of-Network Retail: All charges
If you are provided drugs directly by a physician or covered facility (not a pharmacy); If you receive diabetic supplies (including insulin) or colostomy and ostomy supplies directly from a physician	30% (No deductible)
Over-the-counter (OTC) nicotine replacement therapy or prescription drugs approved by the FDA to treat tobacco dependence are available with a doctor's written prescription only through the Mail Service Pharmacy or at a CVS Pharmacy.	Nothing (No deductible) for OTC and prescription drugs approved by the FDA to treat tobacco dependency. A doctor's written prescription is required.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to treat impotence and sexual dysfunction* • *Vitamins, except as noted above, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription (over-the-counter) medicines, except as noted above*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, *Coordinating benefits with other coverage.*
- 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 calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- 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. See Section 5(c) for inpatient hospital benefits.

Benefit Description	You pay
Accidental injury benefit	
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). The services and supplies must be provided within one year of the accidental dental injury and the patient must be a Plan member when the dental services are received. 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	In-network: 10% of Plan allowance (No deductible) Out-of-network: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Dental Benefit Class A Schedule

Dental benefits		
Service		
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 flouride treatment	$24.00 twice each calendar year	
Space maintainer	$88.00	
Complete X-ray series	$34.00	
Panoramic X-ray	$34.00	

Service - continued on next page

Dental benefits		
Service (cont.)		
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

Dental benefits		
Service		
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 replacements		
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 3/4 cast)	$120.00	
Prefabricated resin and stainless steel	$21.50	
Pontics		
Porcelain and Porcelain with gold	$120.00	
Dentures		
Complete upper and lower	$126.00	
Partial without bar	$138.00	
Partial with bar	$157.00	
Repairs (dentures and partials)	$14.00	

Service - continued on next page

Dental benefits		
Service (cont.)		
Denture relining	$40.50	

Section 5(h). 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 regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
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, except as shown in Section 5(a), Hearing services.
Cancer treatment benefit	We will pay 100% of the Plan allowance for drugs, 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 90% 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 for your routine eye exam each calendar year. Note: The itemized bill must show that you had a routine eye exam to qualify for this benefit.
Coventry Transplant Network	Coventry Health Care has special arrangements with facilities to provide services for tissue and organ transplants. The Coventry Transplant Network is designed to give you the opportunity to access providers that demonstrate high quality medical care for transplant patients.

	Note: If a qualified tissue/organ transplant is medically necessary and performed at a Coventry Transplant Network Facility, you may be eligible for benefits related to expenses for travel, lodging and meals for the transplant recipient and one family member or caregiver. We may also assist you and one family member or caregiver with travel and lodging arrangements. Your physician can coordinate arrangements by calling a case manager in Coventry Health Care's Medical Management Department at 1-800-638-8432. For additional information regarding the Coventry Transplant Network, please call toll-free 1-800-638-8432.
Healthy maternity program	You have access to Coventry Health Care'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.
Case management program	The Case Management Program is a voluntary program provided to you and your dependents at no additional cost. Case management services are designed to assist you, your family and your physician address acute, complex and/or long term medical needs. If you feel you would benefit from case management services or would like more information about the services, please call us toll-free at 1-800-638-8432.
Disease management programs	Disease Management Programs are provided at no additional cost to you. These programs provide 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 Plan members are automatically enrolled in the Program. However, participation is voluntary. The participant and his/her physician remain in charge of the participant's treatment plan. We offer the following Disease Management Programs for these common chronic medical conditions: • Asthma • Chronic Obstructive Pulmonary Disease (COPD) • Congestive Heart Failure (CHF) • Coronary Artery Disease (CAD) • Diabetes If you are enrolled in the Program and do not want to participate or you would like more information about these programs, please call toll-free 1-866-380-6295, Monday through Friday between 10:00 AM and 8:00 PM Eastern Time. In addition, there are Accordant Health Management programs for the following complex chronic medical conditions: • Seizure disorders • Rheumatoid Arthritis (RA) • Multiple Sclerosis (MS) • Crohn's Disease • Parkinson's Disease • Systemic Lupus Erythematosus (SLE) • Myasthenia Gravis • Sickle Cell Disease • Cystic Fibrosis (CF) • Hemophilia

	• Scleroderma • Gaucher Disease • Polymyositis • Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's Disease) • Dermatomyositis • Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP) For more information on the Accordant Health Management programs, please call toll-free 1-866-380-6295.
Travel benefit/services overseas	The Plan has an agreement with AIG Travel Guard 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 AIG Travel Guard 24-hours-a-day, 7-days a week from anywhere in the world for assistance. You may call toll-free at 1-800-988-0638 or collect at 1-715-342-3548 when you are outside the United States.
Genetic testing for prescription drugs	The Plan has partnered with CVS Caremark and its subsidiary, Generation Health, to provide a voluntary genetic testing program for specific prescription medications for which genetic testing is available. Different people respond to medications differently due to their specific genetic make-up and in some cases a prescribed drug may not be the correct treatment option. The Plan will pay 100% of the cost for the genetic testing performed by Generation Health to: • Minimize trial and error in drug prescribing • Determine the right drug and appropriate dosage specifically for the Plan member • Minimize negative side effects of the drug If any of the prescriptions that you are taking qualifies for this benefit, Generation Health will contact the prescribing physician about how to order the appropriate genetic test for you. Generation Health will contact you and ask if you want to participate in the testing program. There is no reduction in Plan benefits if you choose not to participate. If you choose to participate, an easy to use home test kit will be mailed to you with instructions on how to use it. Simply return the test kit in the postage-paid envelope and the test results will be sent to your physician.
Lab Card program	The Lab Card program gives you the option of having covered outpatient laboratory testing paid at 100%, if your covered provider sends your lab work to Lab One/Quest Diagnostics for processing. The Lab Card is an optional program. If you or your provider chooses not to use Lab Card, you will not be penalized. You will simply receive the regular Plan benefit for lab tests (see page 28). The Lab Card covers most outpatient laboratory testing covered by the Plan provided that the tests are ordered by a covered provider and processed by Lab One/Quest Diagnostics. Outpatient lab work covered by the Lab Card Program includes: blood tests (e.g., cholesterol, CBC, thyroid), urine testing (e.g., urinalysis), cytology and pathology (e.g., pap smear, biopsy) and cultures (e.g., throat culture). The Lab Card does not cover: lab tests ordered during a hospital stay, lab work needed on an emergency (STAT) basis and time sensitive lab tests such as fertility testing, bone marrow studies and spinal fluid tests. Lab Card also does not cover x-rays, imaging tests (e.g., CT scans, MRI scans, PET scans), mammography, dental work or lab testing processed by another lab testing company.

	For Lab Card services, please call toll-free 1-800-646-7788 or go to the Lab Card website at www.labcard.com.
Diagnostic imaging program	The Diagnostic Imaging Program provided through US Imaging gives you the option of having your preauthorized CT, MRI and PET scans covered at 100%, if your scan has been preauthorized (see Section 3, *Other Services)* and you choose to have your scan coordinated by and performed at one of US Imaging's nationwide network of contracted free-standing imaging centers. Diagnostic Imaging from US Imaging is a voluntary program. If you choose not to utilize US Imaging, you will not be penalized. You will simply receive the regular Plan benefit for CT, MRI or PET scans (see Section 5(a), Lab, X-ray and other diagnostic tests). The US Imaging Diagnostic Imaging program only covers CT, MRI and PET scans coordinated and performed by the US Imaging nationwide network. Exams not coordinated by US Imaging will be subject to regular Plan benefits included coinsurance and/or deductible. This includes services performed in hospitals or emergency rooms not affiliated with US Imaging. Once you have obtained preauthorization for your scan (See Section 3, *Other Services)* to access the diagnostic imaging benefits of US Imaging and their services,. including scheduling, call toll-free 1-877-874-6385 or go to the US Imaging website at www.usimagingnetwork.com.
Tobacco cessation program	The Tobacco Cessation Benefit is provided through Free & Clear, a division of Alere Health. The program provides: • Up to five proactive coaching classes and unlimited phone calls to Quit Coaches for 12 months for additional support • A personalized quit plan developed by the Plan member with his or her Quit Coach • Unlimited access to Web Coach, an online resource • A printed smoking cessation guide mailed directly to the participant's home • Decision support for tobacco cessation medications (nicotine replacement therapy (NCT), varenicline or buproprion) • Prescription coverage including Chantix and Buproprion with no cost to the participant • Opportunity to reenroll at the end of the program for participants that have not quit or need additional support For additional information on the smoking cessation program or to enroll in the Quit for Life program, call Free & Clear toll-free at 1-866-784-8454.
Pharmacy Advisor Program	If you have one or more of the follwing chronic conditions, you have the opportunity to discuss one-on-one with a CVS Caremark pharmacist any questions or concerns about the medication(s) you are taking. Please call toll-free 1-866-624-1481. • Diabetes • Congestive Heart Failure (CHF) • Coronary Artery Disease (CAD) • Hypertension (high blood pressure) • Dyslipidemia (high cholesterol) • Asthma • Chronic obstructive pulmonary disease (COPD) • Depression • Osteoporosis

	• Breast cancer
My Online Services (Web based customer service)	You can access the Plan's Website tool **My Online Services (MOS)** at http://rcbp.coventryhealthcare.com. Then click on "My Online Services". After you register, this will provide you with secure access to a broad range of your personal health information. **My Online Services** provides tools to help you become an savvy health consumer. The following services are available: • **Interactive Personal Health Record**--The Plan will build your personal health record with information from your claims. You can also add other personal health information such as blood pressure, weight, vital statistics, and immunization records. • **Claims information**--You can view and organize your claims the way you want: sort by date of service, health care provider, procedure, etc. • **Explanation of Benefits (EOB)**--You can access and print your EOBs. • **Authorization notices**--You can view and print your certification for medical services, such as precertification of a planned hospital admission. • **Decision support tools**--You can check the average cost of medical procedures or view hospital quality ratings information before you receive care. • **Health information**--You can obtain health information and news that is relevant to you. • **Interactive health tools**--Assess, understand and manage chronic conditions and health risks. Easy to use content helps Plan members navigate common and complex medical conditions. • **Digital coaching programs**--Includes base programs for weight management, smoking cessation, stress management, nutrition, physical activity (exercise), cholesterol management, blood pressure, depression management, and sleep improvement. Plan members can engage and participate through personalized messages with tools and resources to help keep track of progress and stay on the path to wellness. • **KidsHealth Library**--An online resource provided through Nemours, one of the country's largest pediatric health systems, that educates families and helps them make informed decisions about children's health. KidsHealth has doctor-approved content for parents, children,teens and families.

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 catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1-703-684-5552 or visit their Website at www.nrlca.org.

Long term disability income insurance—The Rural Letter Carrier Long Term Disability (RLCLTD) Income Plan through CIGNA 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 at www.nrlca.org for detailed information or call toll-free 1-800-747-4472**.**

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

Supplemental dental insurance—The NRLCA Dental Plan through the Ameritas Insurance Group is available to all NRLCA members. The Plan features a schedule of benefits for a variety of dental care services. Benefits include:

- Diagnostic and Preventive Care
- Restorative Care
- Endodontic Care (Root Canal Therapy)
- Periodontic Care (Gum Disease)
- Prosthodontics Care (Crowns and Dentures)

This insurance plan is separate from the Federal Employees Dental and Vision Insurance Plan. Please consult the NRLCA Ameritas Dental Plan brochure at www.nrlca.org for detailed information or call toll-free 1-800-747-4472.

Term life insurance--The NRLCA Life Insurance Plan through CIGNA 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 at www.nrlca.org for detailed information or call toll-free 1-800-747-4472.

- Provides up to $200,000 of term life insurance coverage in $25,000 multiples
- Family life insurance coverage up to $50,000 for spouse and $10,000 per child

EyeMed Vision Care Program-- Save up to 40% with the EyeMed Vision Care discount program. Members are eligible for discounts on exams, glasses and contact lenses at thousands of providers nationwide. Members have access to over 33,000 providers including optometrists, ophthalmologists, opticians and leading optical retailers such as: LensCrafters, participating Pearle Vision and Sears Optical locations, Target Optical, JCPenney Optical and many independents. For more information concerning the program or to locate a participating provider, visit the Plan's web site, www.nrlca.org/insurance/Coventry, and select My Online Services (MOS). Once you log on to MOS, select "Wellness Tools", "WellBeing Solutions" and then "Discount Programs" or call toll-free 1-800-638-8432.

QualSight LASIK-- Brings members savings of 40% to 50% off the overall national average price for Traditional LASIK. QualSight's network of the nation's most experienced LASIK surgeons has collectively performed over 2.5 million procedures. Choose from over 800 locations nationwide for your free LASIK consultation to find out if you are a candidate for this life changing procedure. Flexible financing options and Lifetime Assurance plans are available. For more information concerning the program or to locate a participating provider, visit the Plan's web site, www.nrlca.org/insurance/Coventry, and select My Online Services (MOS). Once you log on to MOS, select "Wellness Tools", "WellBeing Solutions" and then "Discount Programs" or call toll-free 1-800-638-8432.

ExtraCare Health Card-- Plan members receive the ExtraCare Health Card from CVS Caremark. This consumer-friendly program is designed to increase satisfaction and provide savings to Plan members and their families at over 7,400 CVS Pharmacy stores and online at www.cvs.com. The ExtraCare Health Card provides a 20% discount on CVS brand health-related items that are eligible for reimbursement under a Health Care Flexible Spending Account (FSA).

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 – services, drugs and supplies we do not cover

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs or supplies for which no charge would be made if the covered individual had no health insurance coverage.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Services, drugs, or supplies for "Never Events". Never Events are errors in patient care that can and should be prevented. The Plan will follow the policies of the Centers for Medicare and Medicaid Services (CMS) for Never Events. The Plan will not cover care that falls under the CMS policies. For additional information, visit www.cms.gov, and enter Never Events in the search box;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to clinical trials for extra care costs and research costs (see definitions);
- 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; or
- Services, drugs, or supplies you receive without charge while in active military service;
- Services, drugs, or supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage, or adoption;
- Services, drugs, or supplies furnished by a facility not covered under the Plan, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits;
- 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 which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 86), doctor's charges exceeding the amount specified by the U.S. Department of Health and Human Services when benefits are payable under Medicare (limiting charge, see page 86) or State premium taxes however applied;
- Custodial care;
- Applied Behavior Analysis (ABA) for Autism Spectrum Disorder
- Services, drugs, or supplies related to weight control or any treatment of obesity except as described in Section 5(a), Medical services and supplies, Section 5(f), Prescription drug benefits, and except for surgery for morbid obesity as described in Section 5(b), Surgical and anesthesia services;
- Nonmedical services such as social services and recreational, educational, visual, and nutritional counseling;
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices;

- Services, drugs, or 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 canceled appointments;
- Charges to copy medical records needed by the Plan to process a claim. If the Plan requests medical records in error, the expenses will be covered;
- 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 or 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 http://rcbp.coventryhealthcare.com.

In most cases, providers and facilities file claims for you. Your physician must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 1-800-638-8432.

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Send your claims to:

Rural Carrier Benefit Plan
P O Box 7404
London KY 40742-7404

Bills and receipts should be itemized and show:

- Name of patient, date of birth and relationship to enrollee;
- Plan identification number of the enrollee;
- Name, address and tax identification number of the person or firm providing the services or supplies;
- Dates that services or supplies were furnished;
- Diagnosis;
- Valid medical or ADA dental code if it exists or a description 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:

- Generally, you need to complete only one claim form each calendar year. You should also complete a new claim form if the claim is for an accidental injury, your mailing address changes, or if your other insurance/Medicare coverage changes.
- You must send a copy of the explanation of benefits (EOB) form you received from any primary payor (such as the Medicare Summary Notice (MSN)) with your claim. See Section 9 for Medicare claims.
- Bills for private duty nursing care in the home must show that the nurse providing the care is a Registered (RN) or Licensed Practical Nurse (LPN). You should also include a copy of the initial history and physical from the attending physician indicating the duration and frequency of the nursing care along with the nursing notes.
- Claims for rental or purchase of durable medical equipment must include the price of the equipment, a prescription and a written statement from the physician specifying the medical necessity, including the diagnosis, and the estimated length of time needed.
- Claims for physical, occupational, and speech therapy must include the initial evaluation and treatment plan along with the length of time that the therapy is needed. Progress (therapy) notes from the therapist(s) for each date of service are also required.
- Claims for dental care must include a copy of the itemized bill from the dentist (including the information above) and the dentist's Federal Tax ID number. The Plan does not have a separate dental claim form.

Please see *Prescription drug benefits,* Section 5(f), for instructions on how to file a claim for prescription drugs that you buy at a non-participating (non-network) retail pharmacy.

Post-service claims procedures

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

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

Records

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

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You should submit your claim in no case more than two years from the date you receive the care. We can extend this deadline if you were prevented from filing your claim 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 on the date the care was received.

When we need more information

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

Authorized representative

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

Notice requirements

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

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

Section 8. The disputed claims process

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to Rural Carrier Benefit Plan, P O Box 7404, London, KY 40742-7404 or calling toll-free 1-800-638-8432.

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

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Rural Carrier Benefit Plan, P O Box 7404, London, KY 40742-7404; 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. e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial.

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

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1-800-638-8432. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 2 at 1-202-606-3818 between 8 a.m. and 5 p.m. Eastern Time.

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

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

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

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

When we are the secondary payor, we 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.

Note: We waive the $200 deductible and the coinsurance for prescription medications purchased at a network retail pharmacy and the copayment for prescription medications purchased through the Plan's mail service pharmacy, when another insurance plan pays first.

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

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

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

We have the right to recover payment we have made to you or on your behalf from any recovery you receive because of illness or injury caused by the act or omission of a third party (another person or organization). This is known as our reimbursement right. In these circumstances, any payments that we make are conditional in nature, and are subject to the following requirements:

If you do not seek damages you must agree to let us try. This is known as our subrogation right. We are also subrogated to your present and future claims against the third party.

Furthermore, if you suffer an injury or illness through the act or omission of a third party, you agree:

- To reimburse us for benefits paid up to the recovery amount from any and all recoveries that you receive; and
- That we are subrogated to your rights to the extent of benefits paid, including the right to bring suit.

All recoveries you receive for damages, from whatever source and however characterized, must be used to reimburse us for benefits we paid for the injury. Unless we agree in writing to a reduction, you cannot reduce our share of the recovery because you do not receive the full amount of damages claimed. Our right of reimbursement is not subject to reduction for attorney's fees under the "common fund" doctrine without our written consent.

If we invoke this provision:

- We will pay benefits for the injury or illness as long as you:
- Take no action to prejudice our ability to recover benefits and;
- Reasonably assist us in recovery.
- Our reimbursement right extends only to the amount we paid or would pay because of the injury or illness.
- We may insist on a proceeds assignment and may withhold payment of benefits otherwise due until the assignment is provided. Failure to request or obtain assignment prior to us paying benefits will in no way diminish our rights of reimbursement and subrogation.

We will have a lien on the proceeds of your claim to the third party to reimburse ourselves the full amount of benefits we have paid or may pay. Our lien will apply to any and all recoveries for the claim and will be satisfied in full out of the proceeds before the satisfaction of any individual’s claim.

You are required to notify us promptly of any claim that you may have for damages as a result of the act or omission of a third party, for which we have paid or may pay benefits. In addition, you are required to notify us promptly of any recovery that you obtain, and you are required to reimburse us from that recovery in full for the benefits paid. Any reduction in our lien for costs including attorney’s fees or any other costs associated with obtaining that recovery must be approved by us prior to payment.

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

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

Clinical trials

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

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

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

When you have Medicare

- **What is Medicare?**

Medicare is a health insurance program for:

- People 65 years of age 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage Plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage Plans on 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 the 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, (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

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

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

(Please refer to page 86 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)

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

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

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care 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 will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

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

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-638-8432.

We waive some costs if the Original Medicare Plan is your primary payor – When Original Medicare is the primary payor, 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 In-network services or the $400 calendar year deductible and coinsurance for Out-of-network services and pay the Part B deductible for you.

Note: We waive the $200 deductible and coinsurance for prescriptions (medications and/or supplies) purchased at a network retail pharmacy and the copayment for prescriptions purchased through the Plan's mail service pharmacy, when Medicare Part B is the primary payor.

Note: We do not waive the $200 deductible for prescription drug expenses when the medication is purchased at a retail pharmacy, except as noted above.

- 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 network hospital or our $300 per admission hospital copayment and coinsurance for a stay in an out-of-network hospital and pay the Part A deductible for you.

- **Tell us about your Medicare coverage**

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

- **Private Contract with your physician**

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

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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

This Plan and another plan's Medicare Advantage 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 a 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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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

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

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

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

If you:

- are age 65 or 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 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
- The law prohibits a hospital from collecting more than the "equivalent Medicare amount".

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

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

If your physician:	Then you are responsible for:
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our provider network,	your deductibles, coinsurance, and copayments.
Participates with Medicare and is **not** in our provider 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.

We use the Department of Veterans Affairs (VA) Medicare-equivalent Remittance Advice (MRA) when the statement is submitted to determine our payment for covered services provided to you, if Medicare is primary, when Medicare does not pay the VA facility.

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 the Medicare carrier that sent you the MSN form. Call us if you need further assistance.

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.

Clinical Trials Cost Categories

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 22.

Convenient care clinic

A small healthcare facility, usually located in a high-traffic retail outlet, with a limited pharmacy, that provides non-emergency basic healthcare services on a walk-in basis. Examples of a convenient care clinic include MinuteClinic in CVS pharmacy locations and Take Care Clinic in Walgreens pharmacy locations. Urgent care clinics are not considered to be convenient care clinics.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 22.

Cost-sharing

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

Covered services

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

Custodial care

Treatment or services, 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 22.

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.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

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 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:

In-network Providers – Our Plan allowance is a negotiated amount between the Plan and the provider. We base our coinsurance on this negotiated amount, and the provider has agreed to accept the negotiated amount as full payment for any covered services rendered. This applies to all benefits in Section 5 of this brochure.

Out-of-network Providers – Our Plan allowance is the lesser of: (1) the provider's billed charge; or (2) the Plan's out-of-network (OON) fee schedule amount. The Plan's OON fee schedule amount is equal to the 90th percentile amount for the charges listed in the Prevailing Healthcare Charges System, administered by Fair Health, Inc. The OON fee schedule amounts vary by geographic area in which services are furnished. We base our coinsurance of this OON fee schedule amount. This applies to all benefits in Section 5 of this brochure. For urine testing services, the Out-of-network allowance is the maximum Medicare allowance for such services.

If you receive services from a participating provider (see Other Participating Providers, page X), the Plan's allowance will be the amount that the provider has negotiated and agreed to accept for the services and or supplies. Benefits will be paid at Out-of-network benefit levels, subject to the applicable deductibles, coinsurance and copayments.

For certain services, exceptions may exist to the use of the OON fee schedule to determine the Plan's allowance for Out-of-network providers, including, but not limited to, the use of Medicare fee schedule amounts. For claims governed by OBRA '90 and '93, the Plan allowance will be based on Medicare allowable amounts as is required by law. For claims where the Plan is the secondary payer to Medicare (Medicare COB situations), the Plan allowance is the Medicare allowable charge.

The plan allowance for Out-of-network emergency services is determined by taking the greatest of: (1) the median in-network rate; (2) the usual, customary and reasonable rate (or similar rate determined using the plans or issuer's general formula for determining payments for Out-of-network services); or (3) the Medicare rate.

The plan allowance for prescription medications is based on the average wholesale price or an alternative pricing benchmark.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

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.

Urgent care claims A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-638-8432. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Urgent care clinic An ambulatory care center, outside of a hospital emergency department, that provides emergency treatment on a walk-in basis for medical conditions that are not life threatening, but need prompt attention.

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. Other Postal Service and Federal Programs

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

Important information about Postal Service and Federal programs that complement the FEHB Program

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

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

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

The 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/or 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. You pay less in taxes so you save money. And, the money you withdraw from the account to pay for eligible expenses is tax-free, too. **Annuitants (retirees) are not eligible to enroll in an FSA.**

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

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, vision care or other insurance plan you or your dependents have. For complete information on eligible health care expenses, please see the brochure, FSA BK1, *Flexible Spending Accounts (November 2013)*, or call the FSA Customer Service Center toll-free at 1-800-842-2026, (TTY 1-888-697-9056).
- Eligible dependents for this account include your spouse, natural born or adopted children who you (or if you are divorced, you or your ex-spouse) may claim as a dependent on your Federal Income tax return or anyone you claim on your Federal Income tax return as a qualified dependent, 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 $2,500 for 2014. The minimum amount is $130.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible **non-medical** dependent care expenses that you incur so you can work. If you are married, it covers eligible dependent care expenses so you and your spouse can both work, or your spouse can look for work (and must have earned income in 2013), attend school full-time or be incapable of self care. For complete information on eligible dependent care expenses, please see the brochure, FSA BK1, *Flexible Spending Accounts (November 2013)*, or call the FSA Customer Service Center toll-free at 1-800-842-2026 (TTY 1-888-697-9056).

- Eligible dependents for this account include children under age 13 and any disabled person you claim on your Federal income tax return as a qualified IRS dependent. For complete information on eligible dependents, please see the brochure, FSA BK1, *Flexible Spending Accounts (November 2013)*, or call the FSA Customer Service Center toll-free at 1-800-842-2026 (TTY 1-888-697-9056).
- The maximum amount that you can contribute to the dependent care flexible spending account is $5,000 for 2014. The minimum amount is $130. For taxpayers who file their taxes separately with a spouse, the maximum is $2,500 per year.

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 (TTY 1-888-697-9056) from 8:00 AM to 10:00 PM , Eastern Time, Monday through Friday, to talk to a representative.

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

Important information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. **This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.** FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an employee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. **Beginning in 2014, most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.**

Vision insurance

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

Additional Information

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

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337, (TTY 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

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

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 High Option of the Rural Carrier Benefit Plan- 2014

- **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 $350 In-network/$400 Out-of-network calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network physician or other health care professional.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	**In-network:** $20/office visit **Out-of-network:** 25% of our allowance and any difference between our allowance and the billed amount*	27
• Surgery	**In-network:** 10% of our allowance (No deductible) **Out-of-network:** 25% of our allowance and any difference between our allowance and the billed amount	40-47
Services provided by a hospital:		
• Inpatient	**In-network:** $100 copayment per admission (waived for maternity stay) **Out-of-network:** $300 copayment per admission; 25% of covered charges	48-49
• Outpatient	**In-network:** 15% of our allowance* **Out-of-network:** 30% of our allowance* and any difference between our allowance and the billed amount	50
Emergency benefits:		
• Accidental injury	Nothing for emergency room visit and first physician office visit	52
• Medical emergency	Emergency room benefits for **In-network** and **Out-of-network** services: 15% of the Plan allowance*	53
Mental health and substance abuse treatment:		
• Inpatient	**In-network:** $100 copayment per admission **Out-of-network:** $300 copayment per admission; 20% for room and board; 20% of other charges.	54-55

High Option Benefits	You pay	Page
• Outpatient	**In-network:** 15% of our allowance* **Out-of-network:** Physician services--25% of Plan allowance and any difference between our allowance and the billed amount* **Facility charges**--30% of the Plan allowance and any difference between our allowance and the billed amount*	55-56 55
Prescription drugs:		
• Network and Non-Network pharmacy	30% of cost*	60-61
• Mail order pharmacy	Up to a 90 day supply: Tier I--$10/generic; Tier II--$30/preferred brand name; Tier III--$47/non-preferred brand name; Tier IV--$80/ Specialty drug	60-61
• Mail order pharmacy with Medicare Part B	Up to a 90 day supply: Tier I--$10/generic; Tier II--$20/preferred brand name; Tier III--$37/non-preferred brand name: Tier IV--$80/ Specialty drug	60-61
Dental care:	Any difference between our scheduled allowance and the billed amount	62-64
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; Lab One program; Smoking cessation program; Diagnostic imaging program; Centers of Excellence; Genetic testing for prescription drugs; Pharmacy Advisor Program	65-69
Protection against catastrophic costs (out-of-pocket maximum)**:**	**In-network:** Nothing after $4,000/person or $4,500/family per calendar year **Out-of-network:** Nothing after $4,500/person or $5,000/family per calendar year **Prescription drugs:** Nothing after $4,500/ person or $5,000/ family per calendar year Note: Benefit maximums apply and some costs do not count toward this protection	24

2014 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 *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to Postal Service employees. They are shown in special Guides published for APWU (including Material Distribution Center and Operating Services) NALC, NPMHU and NRLCA Career Postal Employees (see RI 70-2A); Information Technology/Accounting Services employees (see RI 70-2IT); Nurses (see RI 70-2N); Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees and Postal Career Executive Service employees (see RI 70-2IN); and non-career employees (see RI 70-8PS).

For current career employees covered by the National Rural Letter Carriers' Association (NRLCA) bargaining unit, the Postal Service will pay a greater share of the total health insurance premium. **"Current"** means a career appointment that was effective before July 3, 2012. For new career employees covered by the NRLCA bargaining unit, the Postal Service will pay a lesser share of the total health insurance premium. **"New"** means a career appointment that was effective on or after July 3, 2012.

For further assistance, Postal Service employees should call:

USPS Human Resources Shared Service Center, 1-877-477-3273, option 5, (TTY: 1-866-260-7507)

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Nationwide							
High Option Self Only	381	N/A	N/A	$426.14	$189.13	$70.90	$73.63
High Option Self and Family	382	N/A	N/A	$906.29	$302.10	$104.57	$110.15