Rural Carrier Benefit Plan

www.rcbphealth.com
Customer Service 800-638-8432

2021

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 6 for details. This plan is accredited. See page 11.

IMPORTANT
- Rates: Back Cover
- Changes for 2021: Page 15
- Summary of Benefits: Page 114

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
383 High Option - Self Plus One
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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and 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 is at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have 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 will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

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

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

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

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, an Aetna company. Customer service may be reached at 800-638-8432 or through our website: www.rcbphealth.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 verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2021 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2021 and changes are summarized on page 15. Rates are shown at the end of this brochure.

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 and each covered 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.
- 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 phone or to people you do not know, except for your health care provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your 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 800-638-8432 and explain the situation.

- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE
877-499-7295

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

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

You can also write to:

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

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she was disabled and incapable of self support prior to age 26).
- A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material 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.

Discrimination is Against the Law

The Rural Carrier Benefit Plan complies with all applicable Federal civil rights laws, including Title VII of the Civil Rights Act of 1964.

You can also file a civil rights compliant with the Office of Personnel Management by mail at: Office of Personnel Management Healthcare and Insurance Federal Employee Insurance Operations, Attention: Assistant Director FEIO, 1900 E Street NW, Suite 3400 S, Washington, DC 20415-3610

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

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

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

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail through the Plan or Provider's portal?
- Don’t assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - Exactly what will you be doing?

- About how long will it take?
- What will happen after surgery?
- How can I expect to feel during recovery?

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/**.** The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

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

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

FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

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

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

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

  If you have a Self Only enrollment, you may change to a Self Plus one or 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 Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

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

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-event. If you need assistance, please contact your employing agency, 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 same sex domestic partners) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all 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.

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

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

- **Children's Equity Act**

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

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

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

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

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

- **When benefits and premiums start**

The benefits in this brochure are effective 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 processed according to the 2021 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2020 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 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 additional information about your coverage choices. You can also visit OPM's website, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollees FEHB enrollment.

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). The Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, regardless of marital status, etc. Under TCC, you no longer receive a government contribution, but instead pay the entirety of your premium plus an administration service charge.

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, from your employing or retirement office or from www.opm.gov/healthcare-insurance/healthcare/plan-information/guides. It explains what you have to do to enroll.

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

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.

We will provide you with assistance in finding a non-group contract available inside or outside the Marketplace if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);

- You decide not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

You must contact us in writing within 31 days after you are no longer eligible for coverage. For assistance in finding coverage, please contact us at 800-638-8432.

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

Health Insurance Marketplace

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

Section 1. How This Plan works

This Plan is a fee-for-service (FFS) Plan. You can choose your own physicians, hospitals, and other health care providers. OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. RCBP holds the following accreditation: Comprehensive Plan Management Accreditation from the Accreditation Association for Ambulatory Health Care (AAAHC). To learn more about this plan's accreditation(s), please visit the following websites: www.aaahc.org.

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. Aetna is solely responsible for the selection of network providers in your area. The Plan uses the Aetna Choice POS II (Open Access) network. 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 800-638-8432 or go to our website, www.rcbphealth.com for the names of network providers and to verify their continued participation. You can also reach our web page through the FEHB website, www.opm.gov/insure. Contact Aetna at 800-638-8432 to request a network directory for your area.

Aetna Choice POS II (Open Access) identifies high performing in-network physicians and physician groups in twelve medical specialty areas with an Aexcel designation. See Section 5(h). *Aexcel Designated Providers* for additional information.

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. Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network participation is subject to change. 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, hospitalists, intensivists, 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. Follow these procedures when you use an in-network provider in order to receive in-network benefits:

- Verify that the provider is in the network when you make your appointment. Confirm that the address for your appointment is the same location as on our website. Providers may choose to be an in-network provider at one location but not at another. This information is subject to change at any time. Therefore please check with the provider before scheduling your appointment or receiving services to confirm he or she is participating in the Aetna Choice POS II network.
- Present your Rural Carrier Benefit Plan Identification (ID) Card at the time you visit your health care provider, confirming network participation in order to receive in-network benefits and the provider's continued participation in our network. If you do not present your ID Card, the provider may not give you the in-network discount; and
- Generally, you do not pay an in-network provider at the time of service. In-network providers must bill us directly. We must reimburse the provider directly. In-network providers will bill you for any balance after our payment to them.

This Plan offers you access to certain out-of-network health care providers that have agreed to discount their charges. 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 800-638-8432 for more information about participating providers.

The Plan has networks in all states. The Plan uses the Aetna Choice POS II network. Please check the Plan website at: www.rcbphealth.com or call Aetna at 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 National Standardized Criteria Sets and other nationally recognized guidelines and resources in making determinations regarding inpatient hospital, acute rehabilitation, residential treatment precertification, and therapies that require prior approval (see Section 3, You need prior Plan approval for certain services). These determinations can affect how we provide benefits.

We apply the American Medical Association's (AMA) and /or Centers for Medicare and Medicaid Services (CMS) correct coding guidelines in reviewing billed services and making Plan benefit payments for them. There are exceptions based on benefits, published Medical Policies and when a provider's contract with our network or other participating provider contract stipulates otherwise.

Your rights and responsibilities

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

- Years in existence
- Profit status

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

If you want more information about us, call 800-638-8432 or write to Rural Carrier Benefit Plan, 1630 Duke Street, 2nd Floor, Alexandria, VA 22314-3466. You may also visit our website at www.rcbphealth.com.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website at www.rcbphealth.com To obtain our Notice of Privacy Practices. You can also contact us to request that we mail a copy of that Notice.

Your provider has the responsibility to provide you with complete information about your diagnosis, evaluation, treatment and prognosis. Providers should allow your participation in decisions about your health care. You can understand your rights and responsibilities for your own health care and that of your family members by asking your providers questions. You should:

- Ask questions if you have doubts or concerns and make sure that you understand the answers
- Choose a doctor that you feel comfortable talking to
- Take a family member, relative or friend to your appointments to help you ask questions and understand the answers
- Provide complete and accurate information about your health to your health care provider
- Tell your health care provider about any living will, durable medical power of attorney or other health care directive that could affect your care
- Treat your health care provider with respect
- Follow the treatment plan prescribed by your health care provider.

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 website at: www.rcbphealth.com.

Section 2. Changes for 2021

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. 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 premium will increase for Self Only, Self Plus One and Self and Family coverage. See back cover. *2021 Rates Information.*
- The Plan now covers lab testing through LabCorp in addition to Quest Diagnostics at no member cost share, see Section 5 (a). under *Lab, X-ray and other diagnostic tests.*
- The Plan now covers telemedicine visits for medical, mental and substance use disorders in addition to our telehealth vendor, see Section 5(a), *Diagnostic and treatment services and 5(e), under Professional services.*
- The Plan has changed the cost share for hearing treatment related to non-auditory illness or injury, see Section 5(a). *Diagnostic and treatment services.*
- The Plan now covers physical, occupational and speech therapy for autism and developmental delays with no visit limit, see Section 5(e). under *Outpatient hospital and other outpatient services.*
- The Plan changed the year limit for hearing aids, see Section 5(a), *Orthopedic and prosthetic devices.*
- The Plan has changed the requirements for bariatric surgery. See Section 5(b). under *Surgical procedures.*
- The Plan now pays for observation care over 24 hours at the same benefit level as inpatient benefits, see Section 5(c). under Outpatient hospital or ambulatory surgical center and 5(e). under *Outpatient hospital and other outpatient services.*
- The Plan changed your cost-share for medical emergency services, see Section 5(d). *Medical emergency.*
- The Plan has changed your retail prescription cost-share, see Section 5(f), *Prescription Drug Benefits.*
- The Plan now covers prenatal vitamins under the normal prescription benefit. See Section 5(f). *Covered medications and supplies.*
- The Plan increased the incentive reward for completion of the Health Risk Assessment, see Section 5(h). *Wellness and Other Special Features.*
- The Plan added Sleepio, an online sleep improvement program, see Section 5(h), *Special Features.*
- The Plan has removed the exclusion for conjoint therapy.

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 800-638-8432 or write to us at Rural Carrier Benefit Plan, 1630 Duke Street, 2nd Floor, Alexandria, VA 22314-3466. You may also request replacement cards through our website: www.rcbphealth.com.

Where you get covered care

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

- **Covered providers**

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

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

- **Covered facilities**

Covered facilities include:

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.

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.

Residential Treatment Center – Residential treatment centers (RTCs) are accredited by a nationally recognized organization and licensed by the state, district, or territory to provide residential treatment for medical conditions, mental health conditions, and/or substance abuse. RTCs provide 24-hour residential evaluation, treatment and comprehensive specialized services relating to the individual's medical, physical, mental health, and/or substance abuse therapy needs all under the active participation and direction of a licensed physician who is practicing within the scope of the physician's license. RTCs offer programs for persons who need short-term transitional services designed to achieve predicted outcomes focused on fostering improvement or stability in functional, physical and/or mental health, recognizing the individuality, strengths, and needs of the persons served.

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 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.

You must get prior approval or precertification for certain services. Failure to do so may result in a minimum $500 penalty to be taken from any inpatient or Skilled Nursing facility benefits provided by the Plan. Please see warning under this Section. In addition, we may deny benefits for services listed in this Section under *Other services.*

- **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 will not change our decision on medical necessity.

Warning:

Your in-network physician or hospital will take care of requesting precertification. You should always ask your physician or hospital whether or not they have contacted us for precertification. For out-of-network hospitals and Skilled Nursing Facility admissions, we will reduce our benefits for the out-of-network inpatient hospital, Skilled Nursing Facility stay or residential treatment care by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

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 approval. For a complete list refer to www.aetna.com/health-care-professionals/precertification/precertification-lists.html.

Please call 800-638-8432 for approval for:

- Inpatient confinements (except hospice) For example, surgical and non-surgical stays; stays in a skilled nursing or rehabilitation facility; and maternity and newborn stays that exceed the standard length of stay(LOS)
- Observation stays more than 24 hours
- Ambulance – prior approval required for transportation by fixed-wing aircraft (plane)
- Autologous chondrocyte implantation, Carticel

- Certain mental health services, inpatient admissions, Residential treatment center (RTC) admissions, Transcranial magnetic stimulation (TMS) and Applied Behavior Analysis (ABA)
- Chiari malformation decompression surgery
- Cochlear device and/or implantation
- Covered transplant surgeries
- Dialysis visits – when request is initiated by an in-network provider, and dialysis to be performed at an out-of-network facility
- Dorsal column (lumbar) neurostimulators; trial orimplanation
- Electric or motorized wheelchairs and scooters
- Endoscopic nasal balloon dilation procedures
- Gender reassignment surgery, even if outside of the 50 United States
- Gene therapy, gene editing and gene silencing
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- Lower limb prosthetics
- Out-of-network freestanding ambulatory surgical facility services, when referred by an in-network provider
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)
- Osseointegrated implant
- Osteochondral allograft/knee
- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids
- Proton beam radiotherapy
- Reconstructive or other procedures that maybe considered cosmetic, such as:
  - Blepharoplasty/canthoplasty
  - Breast reconstruction/breast enlargement
  - Breast reduction/mammoplasty
  - Cervicoplasty
  - Excision of excessive skin due to weight loss
  - Gastroplasty/gastric bypass
  - Lipectomy or excess fat removal
  - Surgery for varicose veins, except stab phlebectomy
- Referral or use of out-of-network physician or provider for non-emergent services, unless the member understands and consents to the use of an out-of-network provider under their out-of-network benefits
- Shoulder arthroplasty
- Spinal procedures, such as:
  - Artificial intervertebral disc surgery
  - Cervical, lumbar and thoracic laminectomy/laminotomy procedures
  - Spinal fusion surgery
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices
- Video Electroencephalographic (EEG)

- BRCA genetic testing
- Cardiac rhythm implantable devices
- Hip and knee arthroplasties
- Pain Management
- Pediatric Congenital Heart Surgery
- Polysomnography (attended sleep studies)
- Radiation oncology
- Radiology imaging such as CT scans, MRIs, MRAs, and nuclear

Note: We only cover medically necessary procedures and services. We encourage you to contact the Plan to confirm coverage for proposed treatment prior to incurring services.

Some prescription drugs require prior authorization. Please call 800-237-2767 for approval for:

- Specialty prescription medications and weight management drugs (see Section 5(f))
- Certain compound medications (see Section5(f))

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 800-638-8432 before admission or services requiring prior approval 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 days requested for 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 or not it is an urgent care claim by applying the judgment of a prudent layperson that 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 let you know what information we need to complete our review of the claim. You will have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

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

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 800-638-8432. You may also call OPM's FEHB 2 at 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 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, 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 phone 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 phone 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 3 days after admission for a vaginal delivery or 5 days after admission for 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, your doctor or the hospital must contact us for precertification of additional days for your baby.

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

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

If your hospital stay – including for maternity care 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, we will make a decision within 24 hours after we receive the claim.

If you disagree with our pre-service claim decision

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

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

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

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

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

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

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

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

- **To reconsider an urgent care claim**

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

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

The Federal Flexible Spending Account Program - *FSAFEDS*

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
- FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

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 for a primary care provider and $35 per day for a specialist provider. 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 an In-network hospital, you pay $200 for the first day of your hospital stay and for an Out-of-network hospital; you pay $400 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 $800 per person. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $350 for In-network services or $800 for Out-of-network services under High Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $700 for In-network services or $1,600 for Out-of-network services under High Option. Under a Self and 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 $1,600 for Out-of-network services. Any expenses incurred that apply toward deductibles for in-network or out-of-network apply toward both in-network and out-of-network limits.
- 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. The prescription drug deductible of $200 does not apply to members who have Medicare A and B as primary coverage.
- 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 prior 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 30% 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 30% coinsurance, the actual charge is $70. We will pay $49.00 (70% of the actual charge of $70).

Waivers

In some instances, a provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health Plan. If you sign such a waiver, whether or not you are responsible for the total charge depends on the contracts that 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 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 an In-network provider and when you go to an 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
- Generally, you do not pay an in-network provider at the time of service, except for any copayment that you owe. In-network providers must bill us directly. We must reimburse the provider directly. In-network providers will then bill you for any balance due after our payment to 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 an 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 30% of our $100 allowance ($30). 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	70% of our allowance: $70
You owe: Coinsurance	15% of our allowance: $15	30% of our allowance: $30
+Difference up to charge?	No: $0	Yes: $50
TOTAL YOU PAY	$15	$80

Your catastrophic protection out-of-pocket maximum for 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:

- $5,000 for Self Only enrollment or $10,000 for Self Plus One or Self and Family enrollment when you use In-network providers/facilities and CVS Health In-network retail and/or mail service pharmacy, or
- $7,000 for Self Only enrollment or $14,000 for Self Plus One or Self and Family enrollment when you use Out-of-network providers/facilities and CVS Health Out-of-network retail and/or mail service pharmacy combined. Any expenses incurred that apply toward the catastrophic out-of-pocket maximum for in-network or out-of-network apply toward both in-network and out-of-network limits.
- For Self Plus One and Self and Family enrollments, once any individual family member reaches the Self Only catastrophic protection out-of-pocket maximum during the calendar year, that member's claims will no longer be subject to cost-sharing amounts for eligible medical expenses for the rest of the year. All other family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum.

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

- Expenses covered by specialty drug copay assistance cards for Self Plus One and Self and Family enrollments, once any individual family member reaches the Self Only catastrophic protection out-of-pocket maximum during the calendar year, that member's claims will no longer be subject to cost-sharing amounts for eligible medical expenses for the rest of the year. All other family members will be required to meet the balance of the catastrophic protection out-of-pocket maximumFor Self Plus One and Self and Family enrollments, once any individual family member reaches the Self Only catastrophic protection out-of-pocket maximum during the calendar year, that member's claims will no longer be subject to cost-sharing amounts for eligible medical expenses for the rest of the year. All other family members will be required to meet the balance of the catastrophic protection out-of-pocket maximum

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 prior 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 prior 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 prior 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 prior 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 109-110 are a benefits summary of the high option.

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare 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: **In-network:** $350 for Self Only; $700 for Self Plus One and Self and Family. **Out-of-network:** $800 for Self Only; $1,600 for Self Plus One and Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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.
- **You must get precertification or prior approval for certain services in this Section, such as, but not limited to: electric or motorized wheelchairs, cochlear devices and/or implantation, BRCA genetic testing, radiation oncology, CT scans, MRIs, MRAs and nuclear stress tests.** Please refer to the precertification information shown in Section 3 for additional services requiring prior approval.

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, telemedicine consultations (except surgery) • In physician's office • Medical consultations • In dentist's office in relation to covered oral and maxillofacial surgical procedures • Hearing treatment related to non- auditory illness or disease Note: Primary care physicians are limited to general practitioners, family practitioners, internists and pediatricians. Note: Prior authorization is required for certain specialty self-administered drugs. Call CVS Health at 800-237-2767 prior to scheduling treatment. The drugs are covered under Section 5(f), Prescription drug benefits. Note: We pay for surgery services by a physician under Section 5(b), Surgical services. Note: Telemedicine consultations are covered when your provider uses a Health Insurance Portability and Accountability Act (HIPAA) compliant tool for facilitating telehealth consultations.	In-network primary care provider: $20 copayment (No deductible) In-network specialist provider: $35 copayment (no deductible) Out-of-network: 30% 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.)	
Supplies, other than diabetic supplies, provided by a physician during an office visit are covered under Section 5(a) of the brochure. See Section 5(a), under *durable medical equipment* for coverage of diabetic supplies. Outpatient physical therapy, occupational therapy, and speech therapy are covered under Section 5(a). Treatment for Mental and Behavioral Health Disorders and Substance Use Disorder is covered under Section 5(e).	In-network primary care provider: $20 copayment (No deductible) In-network specialist provider: $35 copayment (no deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Injections	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 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: 30% 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 Note: We cover contraceptive drugs under Prescription Drug Benefits, Section 5(f).	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
Professional non-emergency services provided in a convenient care clinic (except in a MinuteClinic® at CVS) (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: 30% of the Plan allowance and any difference between our allowance and the billed amount.
Professional non-emergency services provided in a MinuteClinic® at CVS	In-network: Nothing (No deductible). Out-of-network: No Benefit
If you are provided drugs (including diabetic drugs) directly by a physician, infusion care provider or durable medical equipment (DME) provider.	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.

Benefit Description	You Pay
Telehealth Services	
Telehealth consultations are available for the following specialties: • Doctors of Medicine (MD) • Registered Dietician (RD) • Licensed Clinical Social Worker (LCSW) • Licensed Mental Health Professionals Please visit www.dialcare.com/verify to register or call 855-335-2255 for information regarding telehealth consults. See Section 5(h). Special features for additional information on telehealth and DialCare. Note: Telehealth is available in all states.	In-network: Nothing (No deductible) if you contact DialCare for services. Out-of-network: No benefit
Not covered: Phone consultations, mailing, faxes, emails or any other communication to or from a physician, hospital or other medical provider except as provided under Diagnostic and treatment services and Telehealth services.	*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 • Ultrasound • Electrocardiogram and EEG • Sonograms • Hearing test for non-auditory illness or disease • Medically appropriate genetic counseling and testing Note: Urine drug testing/screening is covered only as described in "FEHBP Urine Drug Testing Coverage", available on our website, www.RCBPhealth.com, or by calling us at 800-638-8432. Note: The Plan offers confidential phone and web-based genetic counseling services. These services are offered through Informed DNA, a national genetic counseling company staffed with independent board-certified genetic counselors. For more information or to schedule an appointment for genetic counseling, call Informed DNA at 800-975-4819.	In-network: 15% of Plan allowance Out-of-network: 30% 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.

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

Benefit Description	You Pay
Lab, X-ray and other diagnostic tests (cont.)	
• CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT, provided at a stand-alone imaging center or clinic Note: Prior approval for these procedures is required except in the case of an accident or medical emergency. Call us at 800-638-8432 prior to scheduling. See Radiology Imaging under You need prior Plan approval for certain services, Section 3, Other services. Note: If a stand-alone in-network imaging center or clinic is not used, the regular Lab, X-Ray and diagnostic tests benefits above apply. Call us at 800-638-8432 for more details and information about stand-alone imaging centers.	In-network: 5% of Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount. Note: Expenses for related professional services are covered under this benefit
Lab Savings Program	
You may use this voluntary program for covered outpatient lab tests if Quest Diagnostics or LabCorp performs the testing. Show your RCBP identification card each time you obtain lab work and tell your physician you would like to use Quest Diagnostics or LabCorp. If the physician draws the specimen, he/she can call Quest Diagnostics at 800-646-7788 or LabCorp at 888-522-2677 for pick up or you can go to an approved collection site and show your RCBP ID card along with the test requisition from your physician and have the specimen drawn there. Please Note:. To find an approved collection site near you, call Quest Diagnostics at 800-646-7788 or LabCorp at 888-522-2677 or search for Quest Diagnostics or LabCorp using your Zip Code in the Plan's online provider search tool at www.rcbphealth.com.	In-network: Nothing (No deductible) Out-of-network: No benefit Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Savings Program) are subject to applicable deductibles and coinsurance.
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 (which may include certain biometric screening measures such as Body Mass Index (BMI), blood pressure, cholesterol tests, glucose and Hemoglobin A1c tests, colorectal cancer screening performed or ordered by your doctor as part of that annual preventive medical examination) and routine X-rays as recommended preventive services under the Patient Protection and Affordable Care Act. Note: This includes a separate gynecological exam once per calendar year for women.	In-network: Nothing (No deductible) Out-of-network: 30% 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. Note: Any additional medical discussion, procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Screenings such as cancer, depression, diabetes, high blood pressure, HIV, osteoporosis, and total blood cholesterol screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. • Individual counseling on prevention and reducing health risks • Prostate cancer Screening (PSA) - once per calendar year for members age 40 and older • Colorectal cancer screening, including: - Fecal occult blood test - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy screening - every ten years starting at age 50 Note: Age and frequency limitations do not apply to colorectal cancer screenings if there is a family history or high risk factor that indicates the need for screenings. • BRCA risk assessment and genetic counseling and/or testing when recommended by a physician for women who have a family history of breast, ovarian, tubal or peritoneal cancer • Dietary and nutritional counseling for obesity, up to 26 visits combined per calendar year Note: Prior approval is required for BRCA testing (see You need prior Plan approval for certain services, Section 3 under *Other services*). Note: We cover preventive services, counseling and screenings that have a recommendation of "A" or "B" from the United States Preventive Services Task Force (USPSTF) and also covered under the Affordable Care Act (ACA). See Section 10, Definitions, Routine preventive services/immunizations.	In-network: Nothing (No deductible) Out-of-network: 30% 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.)	
Well woman care such as annual counseling for sexually transmitted infections, contraceptive methods, Pap smears, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services go to the Health and Human Services (HHS) website at www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. Note: If you see another physician for your pap smear, the office visit will be covered. Note: Age and frequency limitations do not apply to cancer screenings if there is a family history or high risk factor that indicates the need for screenings.	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) and based on the Advisory Committee on Immunization Practices (ACIP) schedule: • 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 • Pneumococcal vaccine Note: Influenza and pneumococcal vaccines are available at most CVS Health participating (In-network) pharmacies without cost to our Plan members. To find a CVS Health participating pharmacy near you, call 800-292-4182. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ HSS: www.healthcare.gov/preventive-care-benefits/. Women's preventive services: https://www.healthcare.gov/preventive-care-women/.	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)
Not covered: • Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel. • Immunizations, boosters, and medications for travel or work-related exposure.	*All charges*

Benefit Description	You Pay
Preventive care, children	
Well child visits, examinations, and immunizations as described in the Bright Future Guidelines provided by the American Academy of Pediatrics for dependent children under age 22 • Childhood immunizations and well child visits recommended by the American Academy of Pediatrics for dependent children under age 22. Visit www.AAP.org for more information. • 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 • Dietary and nutritional counseling for obesity, unlimited Note: Any additional medical discussion, procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. Note: We cover preventive services, counseling and screenings that have a recommendation of "A" or "B" from the United States Preventive Services Task Force (USPSTF) and also covered under the Affordable Care Act (ACA). See Section 10, Definitions, Routine preventive Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) is available online at: www.uspreventiveservicestaskforce.org HHS: www.healthcare.gov/prevention CDC: www.cdc.gov/vaccines/schedules/index.html **Women's preventive services:** www.healthcare.gov/preventive-care-women/ For additional information: healthfinder.gov/myhealthfinder/default.aspx Note: For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to brightfutures.aap.org/Pages/default.aspx	In-network: Nothing (No deductible) Out-of-network: Nothing up to Plan allowance then the difference between our allowance and the billed amount (No deductible)

Preventive care, children - continued on next page

Benefit Description	You Pay
Preventive care, children (cont.)	
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*
Maternity care	
Complete maternity (obstetrical) care, such as: • Screening for gestational diabetes for pregnant women • Prenatal care (including laboratory tests) • Delivery • Anesthesia • Postpartum care • Sonograms Note: For facility care related to maternity, including care at birthing facilities, we pay at the inpatient hospital rate in accordance with Section 5(c), Inpatient hospital.	In-network: Nothing (No deductible) Out-of-network: 30% 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.
Medically appropriate genetic counseling and testing is covered under *Maternity care* for maternity related genetic tests. Note: The Plan offers confidential phone and web-based genetic counseling services. These services are offered through Informed DNA, a national genetic counseling company staffed with independent board-certified genetic counselors. For more information or to schedule an appointment for genetic counseling, call Informed DNA at 800-975-4819.	In-network: Nothing (No deductible) Out-of-network: 30% 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 Note: Breast pump and supplies are limited to the purchase or rental of standard and hospital grade breastfeeding equipment to an amount no greater than what we would have paid if the equipment had been purchased. We will cover only the cost of standard and hospital grade equipment, which includes the items included in the initial supply kit provided with a new pump order. Note: Breastfeeding supplies such as maternity bras, nursing pads or additional bottles are not covered. Note: When breastfeeding equipment and supplies are purchased at a CVS Pharmacy, you pay nothing (No deductible).	In-network: Nothing (No deductible) Out-of-network: 30% 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: Here are some things to keep in mind: • You do not need to precertify your vaginal delivery; see Section 3. How You Get Care for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 3 days after admission for a vaginal delivery and 5 days after admission for 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 Plus One or 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. • For services related to an accidental injury or medical emergency, see Section 5(d). • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment she may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation.	
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*

Benefit Description	You Pay
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) • 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). Note: For genetic counseling and testing, please refer to Section 5(a) *Lab, X-ray and other diagnostic tests.*	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination (AI)* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intra-fallopian 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 or egg*	*All charges*

Benefit Description	You Pay
Infertility services	
Diagnosis and treatment of infertility (See Definitions, Section 10), 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 Note: Preauthorization is required for certain specialty self-administered drugs. Call us at 800-237-2767 prior to scheduling treatment. The drugs are covered under Section 5(f), Prescription drug benefits.	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: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *Artificial insemination (AI)* - *In vitro fertilization (IVF)* - *Embryo transfer and gamete intrafallopian transfer (GIFT) and zygote intra-fallopian 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*
Allergy care	
• Testing, including the RAST test, and treatment, including materials (such as allergy serum) Note: If your physician uses the Quest Diagnostics or LabCorp to test your specimen, you will pay nothing for the lab test. Note: The allergy services are included in the office visit copayment if performed during an office visit with a network provider.	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: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Allergy injections	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:	*All charges*

Allergy care - continued on next page

Benefit Description	You Pay
Allergy care (cont.)	
• *Food tests* • *End point titration techniques* • *Sublingual allergy desensitization* • *Hair analysis*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 46-49. • Intravenous (IV)/infusion therapy – home IV and antibiotic therapy • Human growth hormone therapy (HGHT) • Respiratory and inhalation therapies • Cardiac rehabilitation therapy Note: We cover only Phase 1 and 2 for cardiac rehabilitation therapy. • Biofeedback only when treating incontinence, migraines, pain management, temporomandibular joint (TMJ) and irritable bowel syndrome (IBS). Note: Applied Behavioral Analysis (including the assessment) is covered under Section 5(e). Mental Health and Substance Use Disorder Benefits and requires prior approval. (See Section 3. under How you get care.) Note: Preauthorization is required for certain specialty self-administered drugs. Call us at 800-237-2767 prior to scheduling treatment. The drugs are covered under Section 5(f), Prescription drug benefits.	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 Note: The Plan pays for services, supplies, and tests rendered for the direct treatment of cancer under Special features, Section 5(h). Note: The Plan pays for services, supplies, and testing for kidney (renal) dialysis under Special features, Section 5(h).
Physical and occupational and speech therapies	
For physical therapy, speech therapy and occupational therapy: • 90 total combined visits per calendar year Note: We provide physical, occupational and speech therapy for those diagnosed with Autism. Note: For physical, occupational and speech therapy for autism and developmental delays, see Section 5(e), Physical, occupational and speech therapies. Note: Inpatient physical, occupational and speech therapies are covered under Section 5(c).	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: • *Long-term rehabilitative therapy*	*All charges*

Physical and occupational and speech therapies - continued on next page

Benefit Description	You Pay
Physical and occupational and speech therapies (cont.)	
• *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. Note: For benefits for adult hearing devices, see Section 5(a) Orthopedic and prosthetic devices.	In-network: Nothing (No deductible) Out-of-network: Nothing (No deductible)
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: Diabetic retinal eye exams are covered under Section 5(a). Diagnostic and treatment services.	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
Routine eye exam, including refractions Note: The itemized bill must show that you had a routine eye exam to qualify for this benefit.	In-network: Nothing up to $45 per adult, then all charges (No deductible) Out-of-network: Nothing up to $45 per adult, then all charges (No deductible)
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: 30% 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 • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as cochlear implants, bone anchored hearing aids (BAHA), 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: 30% of the Plan allowance and any difference between our allowance and the billed amount
• Up to $500 for wigs needed as a result of chemotherapy or radiation treatment for cancer	In-network: Nothing up to $500, then all charges (No deductible) Out-of-network: Nothing up to $500, then all charges (No deductible) Note: This benefit is available once per calendar year.
Hearing aids for adults • Adult hearing aids and related services.	In-network: Nothing up to $3,000 per adult, then all charges (No deductible) Out-of-network: Nothing up to $3,000 per adult, then all charges (No deductible) Note: This benefit is available once every three 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: 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: • *Corsets, trusses, 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 • Diabetic supplies • Elastic stockings and support hose that require a physician's or other health care professional's written prescription • Medical foods and nutritional supplements when administered by catheter or nasogastric tube • 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 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. Note: We will only cover the cost of standard equipment. Coverage for specialty items such as all terrain wheelchairs is limited to the cost of the standard equipment.	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

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	
Note: We cover durable medical equipment (DME) at the In-network benefit level only when you use an In-network DME provider. In-network physicians, facilities, and pharmacies are not necessarily In-network DME providers. Note: We will cover charges for service contracts for medically necessary durable medical equipment that is purchased or rented.	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
Augmentative and alternative communications (AAC) devices such as: • Computer story boards • Light talkers • Enhanced vision systems • Speech aid prosthesis for pediatrics • 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* • *Desktop and laptop computers, pagers, personal digital assistants (PDAs), smart phones, and tablet devices (e.g., iPad), or other devices that are not dedicated speech generating devices* • *Oral nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your state law*	*All charges*
Home health services	
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 of a licensed social worker are included in the 90 visit calendar year maximum.	In-network: 15% of the Plan allowance (No deductible). You pay all charges after 90 visits per calendar year. Out-of-network: 30% 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.

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	
Note: For physical, occupational and/or speech therapy services performed during a home health visit see Section 5(a), *Physical, occupational and speech therapy.*	
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services consisting of only hygiene, feeding, exercising, moving the patient, homemaking, companionship, or giving oral medication;* • *Custodial care as defined in Section 10*	*All charges*
Chiropractic	
• Manipulation of the spine and extremities	In-network: $20 copayment per visit (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	
Acupuncture 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: 30% 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.
Massage therapy only when performed by a covered provider (see Section 3) limited to 30 visits per person, per calendar year Note: Massage therapy is limited to one visit per day. Note: These providers are required to submit itemized bills and their Federal Tax I.D. Number (if a United States provider) as outlined in Section 7, Filing a claim for covered services.	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: 30% 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* • *Rolfing* • *Cupping*	*All charges*

Benefit Description	You Pay
Educational classes and programs	
Tobacco Cessation Program • Two quit attempts per calendar year as part of the Plan's tobacco and nicotine cessation Program. The quit attempts include proactive phone counseling and up to four tobacco cessation counseling sessions of at least 30 minutes each in each quit attempt. Note: Over-the-counter (OTC) and prescription medications approved by the FDA to quit smoking (vaping) or other nicotine use can be obtained at no charge (see Section 5(f), Prescription drug benefits for more details). Note: To enroll in the program, contact a Health Coach at 855-553-5109. Coaches are available Monday – Thursday from 8:00 a.m. – 10:00 p.m. E.T. and Friday from 8:00 a.m. – 6:00 p.m. E.T. You may also enroll online at enroll.trestletree.com (passcode: RCBP).	In-network: Nothing (No deductible) Out-of-network: Nothing (No deductible)
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: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Telephonic Health Coach Program The Telephonic Health Coach program provides you and your covered dependents the opportunity to work one-on-one with a Health Coach to improve your health. A Health Coach is a healthcare professional who partners with you to transform your health goals into action. Your Health Coach will provide guidance, support, and resources to help you overcome obstacles that may be keeping you from realizing optimal health. You can talk to a Health Coach about the following health-related matters: • Tobacco cessation • Weight management • Exercise • Nutrition • Stress management See the Plan's benefit, Telephonic Health Coach Program, in Section 5(h), Special features	In-network: Nothing (No deductible) Out-of-network: No benefit
Not covered: • *Body composition analysis* • *Nutritional supplements or food, except those covered under Section 5(a), Durable medical equipment*	*All charges*

Educational classes and programs - continued on next page

Benefit Description	You Pay
Educational classes and programs (cont.)	
• *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 Healthcare 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: **In-network:** $350 for Self Only; $700 for Self Plus One and Self and Family. **Out-of-network:** $800 for Self Only; $1,600 for Self Plus One and Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES INCLUDING, BUT NOT LIMITED TO: TRANSGENDER SURGICAL SERVICES (GENDER REASSIGNMENT SURGERY), BARIATRIC SURGERY AND ORGAN/TISSUE TRANSPLANTS.** Please refer to the precertification information shown in Section 3 for additional services requiring prior approval.
- **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) • Circumcision • Treatment of burns	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

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Surgical procedures (cont.)	
Gender reassignment surgery to treat gender dysphoria – In order for the Plan to consider benefits, all of the following Plan requirements must have been met: 1) You must be at least 18 years old; 2) You have been diagnosed with gender dysphoria, as determined by the Plan; 3)You have obtained prior approval for the surgery even if the proposed treatment is outside of the 50 United States (see Section 3, Other services); and 4)You have completed a recognized program of gender dysphoria treatment to include but not limited to, well documented gender dysphoria. Covered surgical procedures, limited to: • For female to male surgery: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty, and placement of testicular and erectile prosthesis • For male to female surgery: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty *Note: For further preauthorization requirements specific to your gender reassignment surgery, please call 800-638-8432.*	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
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, 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 three months in length; and (4) has completed a psychological exam. Insertion of internal prosthetic devices. See Section 5 (a), Orthopedic and prosthetic devices for device coverage information	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
• Voluntary male sterilization (e.g., vasectomy) • 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: 30% 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.)	
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: 50% of the Plan allowance (unless the network contract or other participating provider contract provides for a different amount) • For tertiary and subsequent procedures: 25% of the Plan's allowance (unless the provider is an in-network or other participating provider in the United States and their 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: 15% of the Plan allowance for the primary procedure (No deductible) Out-of-network: 30% 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 or other participating provider contract provides for a different amount.	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
Assistant Surgeons 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, and is 12% of the allowance for the surgery when provided by a non-physician (such as but not limited to physician assistant, nurse practitioner, or clinical nurse specialist) or when minimum surgical assistant services are provided (unless the network contract or other participating provider contract provides for a different amount).	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
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*	*All charges*

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Surgical procedures (cont.)	
• *Mutually exclusive procedures-- surgical procedures that are not generally performed on one patient on the same day* • *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.* *Note: We define cosmetic surgery as any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form except for coverage for gender reassignment surgery as noted on the previous page.* • *Gender reassignment surgery, other than the surgeries listed as covered* • *Reversal of gender reassignment surgery*	*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 Section 5(a), Prosthetic devices for coverage) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	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

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Reconstructive surgery (cont.)	
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* *Note: We define cosmetic surgery as any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form except for coverage for gender reassignment surgery as noted on the previous page*	*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: 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
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. Please see Section 3, Other services for prior approval procedures. Solid organ transplants limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	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

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Cornea • Heart • Heart/lung • Intestinal transplants - Isolated Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung: single/bilateral/lobar • Pancreas	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
These **tandem blood or marrow stem cell transplants for covered transplants** are Not subject to medical necessity review by the Plan. Please see Section 3, Other services for prior approval procedures. • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	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
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below: • **Allogeneic transplants for:** - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Leukocyte adhesion deficiencies - Kostmann's symdrome	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

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal nocturnal hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/myelodysplastic syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • **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 - Ependymoblastoma - Medullablastoma - Ewing's sarcoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors - Waldenstorm's macroglobulinemia	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
Mini-transplants (non-myeloblative reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Please see Section 3, Other services for prior approval procedures. • **Allogeneic transplants for:** - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia	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

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia)-Paroxysmal Nocturnal Hemoglobinuria-Severe or very severe aplastic anemia - Severe combined immunodeficiency - Myelodysplasia/Myelodysplastic syndromes • **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: 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
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. • **Allogeneic transplants for:** - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP)	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

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Paroxysmal Nocturnal Hemoglobinuria (PNH) - Severe or very severe aplastic anemia - Sickle Cell anemia • **Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for:** - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders (MDDs) - Myelodysplasia/Myelodysplastic Syndromes - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • **Autologous transplants for:** - Advanced Hodgkin's lymphoma - Advanced Ewing sarcoma - Advanced Childhood kidney cancers - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin's lymphomas - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)	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

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
- Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis • **Autologous transplants for the following autoimmune diseases:** - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive)	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
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. 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 covered under any other health plan for transplants. Note: We cover donor screening and search expenses for up to four (4) candidate donors per transplant in addition to testing family members. Note: Aetna has special arrangements with transplant facilities to provide services for tissue and organ transplants (see Section 5(h), Special Features, Institutes of Excellence). The transplant network is designed to give you the opportunity to access providers that demonstrate high quality medical care for transplant patients. We also may assist you and one family member or caregiver with travel and lodging arrangements if you use one of our Institutes of Excellence. Your physician can coordinate arrangements by calling Aetna at 800-638-8432.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs*	*All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• *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: When multiple anesthesia providers are involved during the same surgical session, the Plan's allowance for each anesthesia provider will be determined using the Center for Medicare and Medicaid (CMS) guidelines.	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

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: **In-network:** $350 for Self Only; $700 for Self Plus One and Self and Family. **Out-of-network:** $800 for Self Only; $1,600 for Self Plus One and Self and Family. 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), unless billed by the facility.
- 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, hospitalists, intensivists, 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.

NOTE: Observation care is billed as outpatient facility care. As a result, benefits for observation care services are provided at the outpatient facility benefit levels. See Observation care, Section 10, for more information about these types of services.

- **YOUR NETWORK PHYSICIAN OR HOSPITAL MUST PRECERTIFY HOSPITAL OR SKILLED NURSING FACILITY STAYS AND FOR CONCURRENT REVIEW (FOR DAYS BEYOND THE PLAN'S INITIAL APPROVAL) FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL OR SKILLED NURSING FACILITY STAYS AND FOR CONCURRENT REVIEW FOR OUT-OF-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR OUT-OF-NETWORK FACILITY CARE. Please refer to the precertification information shown in Section 3 to confirm 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, then we will consider the private room rate. 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 medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services 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, unless billed by the facility.	In-network: $200 copayment for each hospital admission (copayment waived for a maternity stay) Out-of-network: $400 copayment for each hospital admission and 30% 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 other medically necessary services and supplies you received other than room and board and in-hospital physician care at the inpatient level.* • *Hospital charges for non-covered surgery*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
• *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* • *Personal comfort items, such as phone, 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, including observation care less than 24 hours • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • 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 to safeguard the health of the patient, even though we may not cover the services of dentists, physicians or other health care professionals in connection with the dental treatment. 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)
Outpatient observation care 24 hours or more performed and billed by a hospital or freestanding ambulatory facility. Note: All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. See Section 5(a) for services billed by professional providers during an observation stay.	In-network: $200 copayment for each hospital admission (copayment waived for a maternity stay) Out-of-network: $400 copayment for each hospital admission and 30% of the covered charges
Not covered: • *Outpatient hospital services/supplies for surgery we do not cover except as noted above.*	*All charges*

Benefit Description	You Pay
Extended care benefits/Skilled nursing care facility benefits	
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 Note: If Medicare pays first for your care, the first 20 days of your stay (paid in full by Medicare) do not count toward the 60-day benefit limit each calendar year. Note: Skilled nursing facility admissions require precertification; failure to do so will result in a minimum $500 penalty.	In-network: $200 copayment for each admission and all charges in excess of the 60-day maximum Out-of-network: $400 copayment for each admission, 30% of the covered charges and all charges in excess of the 60-day maximum and the difference between the Plan allowance and the billed amount
Not Covered: • *Custodial care*	*All charges*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care designed to provide palliative and supportive care to members with a projected life expectancy of six (6) months or less due to a terminal medical condition, as certified by the member's physician or specialist 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. Note: See Section 5(h) Special Features, under *Aetna In Touch Care Program*, for more information on advance care planning.	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* • *Homemaker services* • *Home hospice care (e.g., care given by a home health aide) that is provided and billed for by other than the approved home agency when the same type of care is already being provided by the home hospice agency.*	*All charges*

Benefit Description	You Pay
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 for your own or your family's convenience* • *Transportation to other than a hospital, skilled nursing facility, dialysis, hospice or urgent care medical facility* • *Ambulance and any other modes of transportation to or from services including, but not limited to, physician appointments, or diagnostic tests, except as part of covered inpatient hospital care*	*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: **In-network:** $350 for Self Only; $700 for Self Plus One and Self and Family. **Out-of-network:** $800 for Self Only; $1,600 for Self Plus One and Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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.
- When you use and in-network facility, keep in mind that the health care professionals who provide services to you in the facility may not be in-network providers. We will pay up to the Plan allowance at the in-network provider percentage for services you receive from out-of-network anesthesiologists (including Certified Registered Nurse Anesthetists), radiologists, pathologists, emergency room physicians, hospitalists, intensivists, neonatologists, and surgeons when immediate or emergency care is required. You will be responsible to pay the in-network coinsurance and any difference between the Plan allowance and billed amount for these out-of-network providers.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.

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 Section 5(g), Dental benefits.

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); • Series of Rabies vaccinations 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 primary care provider's office--**$20 copayment (No deductible) In-network: **Services in a specialist provider's office**-$35 copayment (no deductible) Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) In-network: **Services outside the primary care provider's or specialist provider's office—** $200 copayment (No deductible) Out-of-network: **Services outside the primary care provider's or specialist provider's office—** $200 copayment and any difference between our allowance and the billed amount (No deductible)
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: 30% 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* • *Transportation to other than a hospital, skilled nursing facility, dialysis, hospice or urgent care medical facility*	*All charges*

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

You need to get prior Plan approval or precertification. Benefits are payable only when we determine the care is clinically appropriate to treat your condition. To be eligible to receive full benefits, you must follow the precertification or prior approval process and get Plan approval of your treatment plan. **Please Section 3 of this Brochure for a list of services that require precertification or prior approval.**

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. The calendar year deductible is: **In-network:** $350 for Self Only; $700 for Self Plus One and Self and Family. **Out-of-network:** $800 for Self Only; $1,600 for Self Plus One and Self and Family.
- 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, including Medicare, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION OR PRIOR APPROVAL FOR:**
  - Inpatient admissions
  - Residential treatment center (RTC) admissions
  - Transcranial Magnetic Stimulation (TBS)
  - Applied Behavior Analysis (ABA)

Note: Your in-network physician or hospital must precertify or obtain prior approval for the services listed above, including concurrent review (for days or visits beyond the Plan's initial approval). You must precertify or obtain prior approval for the services listed above for out-of-network physician or hospital, including concurrent review (for days or visits beyond the Plan's initial approval). **FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR OUT-OF-NETWORK FACILITY CARE.** Please refer to the precertification information shown in Section 3 to confirm which services require precertification.

- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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, including telemedicine consultations by licensed professional mental health and substance use disorder treatment 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: • Psychiatric office visits to behavioral health practitioner • Substance Use Disorder (SUD) office visits	In-network: $20 copayment (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Professional services - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Professional services (cont.)	
• Behavioral therapy • Telemedicine consultations Note: Telemedicine consultations are covered when your provider uses a Health Insurance Portability and Accountability Act (HIPAA) compliant tool for facilitating telehealth consultations.	In-network: $20 copayment (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Applied Behavioral Analysis (ABA) The Plan covers medically necessary applied behavioral analysis therapy including the assessment only when provided by behavioral health providers. These providers include: • Providers who are licensed or who possess a state-issued or state-sanctioned certification in ABA therapy. • Behavior analyst certified by the Behavior Analyst Board (BACB) • Registered Behavior Technicians (RBTs) certified by the BACB or equivalent paraprofessionals who work under the supervision of a licensed provider or a certified behavior analyst. NOTE: Assessment and treatment for ABA requires prior approval. See Section 3, How you get care for information on how to precertify and obtain prior approval for your care.	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
Skilled behavioral health services provided in the home, but only when all of the following criteria are met: • You are homebound • Your physician orders the services • The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home • The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications	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
Telehealth consults are available for the following specialties: • Doctors of Medicine (MD) • Registered Dietician (RD) • Licensed Clinical Social Worker (LCSW) • Licensed Mental Health Professionals Please visit www.dialcare.com/verify to register or call 855-335-2255 for information regarding telehealth consults. See Section 5(a). Diagnostic and treatment services and Section 5(h). Special features for additional information on telehealth and DialCare. Note: Telehealth is available in all states.	In-network: Nothing (No deductible) if you contact DialCare for services. Out-of-network: No benefit

Professional services - continued on next page

Benefit Description	You Pay After the calendar year deductible…
Professional services (cont.)	
AbleTo is a web-based video conferencing personalized 8-week treatment support designed to address the unique emotional and behavioral health needs of individuals learning to live with conditions like heart disease, type 2 diabetes, chronic pain or life events like losing a loved one or having a baby. Note: AbleTo support is available to all members in the 50 United States. Note: See Section 5(h), *AbleTo Support Program* for additional information about this program.	In-network: Nothing (No deductible) Out-of-network: No benefit
Diagnostics	
• Psychological testing provided and billed by a licensed mental health and substance use disorder treatment 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: 30% of the Plan allowance any difference between our allowance and the billed amount
Physical, occupational and speech therapies	
Outpatient physical, occupational, and speech therapy visits for the diagnosis of autism and developmental delays.	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
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility, including an overnight residential treatment facility (RTC) **Note:** RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, therapeutic boarding school, halfway house, or similar type facility. **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, then we will consider the private room rate. **Note:** Benefits are not available for non-covered services, including but not limited to: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, television, beauty and barber services; custodial or long term care ; and domiciliary care provided because care in the home is not available or is unsuitable.	In-network: $200 copayment for each hospital admission (No deductible) Out-of-network: $400 copayment for each hospital admission and 30% of the covered charges (no deductible)

Benefit Description	You Pay After the calendar year deductible…
Outpatient hospital or other outpatient services	
Outpatient services provided and billed by a hospital or other covered facility All other outpatient mental health treatment, including: • Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician • Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician • Outpatient detoxification • Ambulatory detoxification which is outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications • Treatment of withdrawal symptoms • Electro-convulsive therapy (ECT) • Mental health injectables • Substance abuse injectables • Transcranial magnetic stimulation • Observation 24 hours or less Note: Partial hospitalization programs must be licensed to provide mental health and/or substance use disorder treatment. Services must be at least four hours per day and may include group, individual, and family therapy along with psychoeducational services and adjunctive medication management. Note: Intensive outpatient programs must be licensed to provide mental health and/or substance use disorder treatment. Services must be provided for at least two hours per day and may include group, individual, and family therapy along with psychoeducational services and adjunctive psychiatric medication management.	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
Outpatient observation care 24 hours or more performed and billed by a hospital or freestanding ambulatory facility Note: All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. See Section 5(a) for services billed by professional providers during an observation stay.	In-network: $200 copayment for each hospital admission (No deductible) Out-of-network: $400 copayment for each hospital admission and 30% of the covered charges (no deductible)
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*	*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 68.
- 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.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- The calendar year prescription drug deductible is: $200 per person. The prescription drug deductible of $200 does not apply to members who have Medicare A and B as primary coverage. 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 or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.

Where you can obtain your prescription? You may fill the prescription at a CVS Health participating pharmacy, a non-network pharmacy, or through the CVS Health mail service prescription program for a maintenance medication.

- **CVS Health participating (In-network) pharmacy:** You may fill your prescription at any CVS Health participating pharmacy. To find a participating pharmacy near where you live, call CVS Health toll-free at 800-292-4182 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 Health logo) 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 Health participating pharmacy and show your Plan ID card. The participating pharmacy will file the claim with CVS Health for you. **Prescriptions you purchase at a CVS Health network pharmacy without using your ID card are at the full regular price charged by the pharmacy. If you do not show your ID card at a participating pharmacy, you will need to file a claim with CVS Health.**
- **Non-participating (Out-of-network) pharmacy:** You may fill your prescription at any out-of-network pharmacy. You pay the full regular price for your prescription and then file a claim with CVS Health.
- **CVS Health mail service pharmacy:** You may fill your long-term prescription through the CVS Health mail service pharmacy. You will receive order forms and information on how to use the mail service prescription program from CVS Health. To order your prescription by mail: 1) complete the CVS Health order form; 2) enclose your prescription(s) and copayment(s); 3) mail your order to CVS Health, 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 phone toll-free at 800-292-4182 or on the Internet at www.Caremark.com

CVS Health's Primary/Preferred Drug list

The CVS Health Primary/Preferred Drug list is a list of "preferred" prescription drugs that are identified by the CVS Health 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 Health Customer Service Department at 800-292-4182 or visit our website at www.nrlca.org and click on Departments, then Insurance.

We also cover certain 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.

Specialty medications are typically high-cost, biologic drugs with complex dosing regimens, significant side effects, or alternate routes of administration such as injections and infusions. The Advanced Control Specialty Formulary ensures the safety and effectiveness of specialty medications and promotes the use of specialty generics in applicable situations Visit info.caremark.com/acsdruglist for a list of the specialty medications formulary.

- **Prior Authorization:** We require prior authorization for certain drugs, including specialty and weight management medications. To obtain a list of drugs that require prior authorization, please call the CVS Health Customer Service Department at 800-292-4182. The prior authorization drug list is reviewed by the CVS Health 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 Health Prior Authorization Department at 855-240-0536. CVS Health will work with your physician to obtain the information we need to process the request. You may contact the CVS Health Customer Service Department for the status of your request at 800-292-4182.

Compound Medication: A compound drug is a medication made by combining, mixing or altering ingredients in response to a prescription, to create a customized drug that is not otherwise commercially available.

Coverage for certain compounding chemicals (over-the-counter (OTC) products, bulk powders, bulk nutrients, bulk compounding agents, bulk chemicals, hormone and adrenal bulk powders, miscellaneous bulk ingredients, and proprietary bases are not covered through the prescription benefit and coverage for other ingredients commonly found in compound prescriptions will be determined through preauthorization. Refill limits may apply. When a claim is submitted for online processing or direct reimbursement of a compound medication, the pricing is based on the contractual discounts plus a professional fee and any applicable sales tax. Pharmacies must submit all ingredients in a compound prescription as part of the claim for both online claims and paper claim submissions. At least one of the ingredients submitted with the compound Rx claim must require a physician's prescription in order to be covered by the plan. You are responsible for the appropriate brand name or generic copay or coinsurance based on the compound ingredients. **Prior authorization may be required.** Investigational drugs are not FDA approved. If the compound includes an investigational drug, the compound will not be covered.

Topical Analgesics: Certain topical analgesics for the temporary relief of minor aches and muscle pains may be marketed contrary to the Federal Food, Drug and Cosmetic Act (the FD&C Act) and are excluded by the Plan. Your prescription drug benefit includes other medications that are approved by the U.S. Food and Drug Administration (FDA) for the temporary relief of minor aches and muscle pains by means of the prescribed route of administration.

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 physician. You must purchase certain specialty drugs, including biotech, biological, biopharmaceutical, and oral chemotherapy drugs through a CVS Health Specialty Pharmacy.

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

Certain specialty self-administered medications will be covered only when purchased through a CVS Health Specialty Pharmacy and will not be covered under any other Plan benefit. A list of these specialty self-administered medications is available at www.caremark.com. This list is subject to periodic change. Please call CVS Health at 800-237-2767 for the current list of specialty medications covered under the prescription drug benefit when purchased through a CVS Health Specialty Pharmacy.

Infusion Nursing and Site of Care Management for Specialty Medications

Infusion nursing services for certain specialty medications that are administered in the home and/or in an ambulatory infusion center are covered, coordinated through, and must be purchased from a CVS Health Specialty Pharmacy. For infused specialty medications, except for oncology (cancer) medications, that require administration by a medical professional, a CVS Health Care Team nurse will work with you and your physician to assess your clinical history and determine clinically appropriate options (location for your infusion) for clinician-infused specialty medications. Options may include homecare, an ambulatory infusion center, or physician's office. Care Team nurses will contact all impacted Plan members to provide assistance and guidance. Please call 800-237-2767 for complete information.

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 of 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 third fill at a network retail pharmacy, you must purchase your long-term medications through the CVS Health 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 Health for reimbursement after you satisfy the annual $200 prescription drug deductible (see page 59).
- 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 Health 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 Health will return the refill request to you. CVS Health 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 Health 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 Health 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 Health participating pharmacy or at a non-participating pharmacy. However, your copayment is reduced for 90-day prescriptions that you order through the CVS Health 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 Health 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 Health 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 Health. Use the CVS Health prescription claim form and send your claim to:

CVS Health, PO Box 52136, Phoenix, AZ 85072-2136

Claims for prescription drugs and supplies that are not ordered through the CVS Health mail service prescription program or a CVS Health In-network pharmacy must include receipts that have the patient's name, the prescription number, name of the drug, day supply, the medication's National Drug Code (NDC), prescribing physician's name, date, charge, and pharmacy name. The pharmacist must sign any computer printout or pharmacy ledger. Prescription claim forms are available by calling toll-free 800-292-4182 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 medications (including those administered during a non-covered admission or in a non-covered facility) that require a physician's written prescription under U.S. Federal law, except those listed as *Not covered* • Vitamins and minerals that require a physician's prescription for purchase under U.S. Federal law • Insulin and diabetic supplies such as test strips, lancets, etc. • Disposable needles and syringes for the administration of covered medications	In-network Retail: • Generic: 30% of cost; maximum $7.50 per prescription • Preferred brand name (formulary): 30% of cost; maximum $200 per prescription • Non-Preferred brand name (non-formulary); maximum $200 per prescription In-network Retail when retired with Medicare Part B coverage: • Generic: 30% of cost; maximum $7.50 per prescription • Preferred brand name (formulary): 30% of cost; maximum $200 per prescription • Non-Preferred brand name (non-formulary); maximum $200 per prescription Out-of-network Retail: 30% of cost Out-of-network Retail when retired with Medicare Part B coverage: 30% of cost

Covered medications and supplies - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Covered medications and supplies (cont.)	
• Tobacco cessation drugs and medications. See also Educational classes and programs in Section 5 (a), Medical services and supplies for information about the Plan's Tobacco Cessation Program • Prescription drugs for weight management Note: Prescription drugs for weight management require prior authorization. Note: Colostomy and ostomy supplies are covered under Section 5(a), Durable medical equipment. Note: A blood glucose meter can be provided at no charge. For more information on how to obtain a blood glucose meter, call toll-free: 800-588-4456.	In-network Retail: • Generic: 30% of cost; maximum $7.50 per prescription • Preferred brand name (formulary): 30% of cost; maximum $200 per prescription • Non-Preferred brand name (non-formulary); maximum $200 per prescription In-network Retail when retired with Medicare Part B coverage: • Generic: 30% of cost; maximum $7.50 per prescription • Preferred brand name (formulary): 30% of cost; maximum $200 per prescription • Non-Preferred brand name (non-formulary); maximum $200 per prescription Out-of-network Retail: 30% of cost Out-of-network Retail when retired with Medicare Part B coverage: 30% of cost In-network Mail Service: • Tier I: $10 generic (No deductible) • Tier II: $50 brand name on primary drug list (No deductible) • Tier III: $80 brand name not on primary drug list (No deductible) • Tier IV: Speciality drugs $80 (no deductible) for a 30 day supply and $125 for a 90 day supply (no deductible) In-network Mail Service when retired with Medicare Part B coverage: • Tier I: $10 generic (No deductible) • Tier II: $40 brand name on primary drug list (No deductible) • Tier III: $70 brand name not on primary drug list (No deductible) • Tier IV: Speciality drugs $80 (no deductible) for a 30 day supply and $125 for a 90 day supply (no deductible) Note: If there is no generic equivalent available, you must pay the brand name copayment. Note: For long-term maintenance medications, you are limited to the initial prescription and two refills at a CVS Health In-network (participating) pharmacy or at an Out-of-network (non-participating) pharmacy. You must use the Mail Service pharmacy or a CVS Pharmacy for a continuing supply of the medication after three fills.

Covered medications and supplies - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Covered medications and supplies (cont.)	
	Note: For long-term maintenance medications (90-day supply) purchased at a CVS Pharmacy, you pay the same copayments (No deductible) as the In-network Mail Service Pharmacy.
Drugs and diabetic supplies (including insulin), when Medicare Part B is the primary payer. Note: You must show your Medicare ID card at the pharmacy when purchasing these items in order to receive the maximum benefit.	Nothing (No deductible) when filed with Medicare Part B first.
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	In-network Retail: Nothing (No deductible) Out-of-network Retail: 30% of cost (No deductible) In-network Mail Service: Nothing (No deductible)
Medicines to promote better health recommended under the Patient Protection and Affordable Care Act (the Affordable Care Act) and have an "A" or "B" recommendation from the United States Preventive Services Task Force (USPSTF) See Section 10, Definitions, Routine preventive services/ immunizations. 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.	In-network Retail: Nothing Out-of-network Retail: All charges
Narcan (rescue agent) Note: If you are in a state that requires a prescription in order to purchase Narcan, you will have to obtain one from your healthcare provider. Otherwise, you may purchase Narcan without a prescription. Please contact your local network pharmacy for more information.	In-Network Retail: Nothing Out-of-network Retail: Nothing In-network Mail Service: Nothing (No deductible)
Over-the-counter (OTC) nicotine replacement therapy or prescription drugs approved by the FDA to treat and nicotine 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 and nicotine dependency. A doctor's written prescription is required.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to treat impotence and sexual dysfunction*	*All charges*

Covered medications and supplies - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Covered medications and supplies (cont.)	
• *Medical foods and nutritional supplements, except as described in Section 5(a), Durable medical equipment* • *Nonprescription (over-the-counter) medications, except as noted above*	*All charges*
Preventive care medications	
Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Liquid iron supplements for children age 0-1 year • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 Note: To receive this benefit a prescription from a doctor must be presented to pharmacy.	In-network Retail: Nothing Out-of-network Retail: All Charges
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to treat impotence and sexual dysfunction* • *Medical foods and nutritional supplements, except as described in Section 5(a), Durable medical equipment* • *Nonprescription (over-the-counter) medications, 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 benefits	Dental Benefit Class A Schedule
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)	Note: You are responsible for all charges that exceed the Plan's scheduled allowance for the service listed below.
Oral exam	$12.50 twice each calendar year
Prophylaxis, adult and child	$22.00 twice each calendar year
• Prophylaxis with fluoride treatment (thru age 22)	$24.00 twice each calendar year
Space maintainer	$88.00
Complete X-ray series	$34.00
Panoramic X-ray	$34.00
Single intraoral X-ray/bitewing single film	$5.50
Each additional intraoral X-ray (up to 7)	$4.00
Bitewings - 2 films	$9.00
Bitewings - 4 films	$14.00

Dental benefits	Dental Benefits Class B Schedule
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.	Note: You are responsible for all charges that exceed the Plan's scheduled allowance for the service listed below.
Restorations	
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
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	
Periodontal scaling and root planning	$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
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).
Aexcel Designated Providers	**A guide to the Aexcel specialist performance designation** Aexcel is our designation for high-performing specialty physicians and physician groups in twelve medical specialty areas: • Cardiology • Cardiothoracic surgery • Gastroenterology • General Surgery • Neurology • Neurosurgery • Obstetrics and gynecology • Orthopedics • Otolaryngology/ENT • Plastic Surgery • Urology • Vascular surgery Physicians with the Aexcel specialist designation have met added standards for volume, clinical performance, and efficiency. Aetna evaluates these providers using specific standards and, based on the results, gives them the Aexcel specialty designation.

	Visit www.rcbphealth.com and select "Locate a Provider", and look for the blue star next to the provider's name for an Aexcel designated provider. If a specialist does not have a blue star, this does not mean the physician does not provide quality services. It could be that Aetna does not have enough information available to evaluate a particular physician or the physician's specialty is not one of the 12 specialty categories. The Aexcel information is only a guide. There are many ways to evaluate doctor practices. You should talk with your primary care physician and the specialist you are considering before making a decision. Please note that ratings have a chance for error. An Aexcel designation is not a guarantee of service quality or treatment outcome. Therefore, the Aexcel designation should not be the only reason for choosing a specialty doctor.
Institutes of Excellence (IOE)	The Plan has special arrangements with facilities to provide services for tissue and organ transplants only. The transplant network was 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 one of the Institutes of Excellence (IOE) network facilities, you may be eligible for reimbursement of some related to expenses for travel and lodging 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. This benefit does not apply to normal in-network facilities but only to the IOE network facilities. Reimbursement is subject to IRS regulations. Note: Receipts are required for reimbursement of travel and lodging costs. You or your physician can coordinate arrangements by calling a case manager in Aetna's Medical Management Department at 800-638-8432. For additional information regarding the Aetna Transplant Network, please call toll-free 800-638-8432.
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.
Services for deaf and hearing impaired	No benefit, except as shown in Section 5(a), Hearing services.
Informed Health® Line	Informed Health® Line provides eligible members with phone access to registered nurses experienced in providing information on a variety of health topics. Informed Health Line is available 24 hours a day, 7 days a week and can be reached by calling 800-638-8432. We provide TDD service for the hearing and speech-impaired. We also offer foreign language translation for non-English speaking members. Informed Health Line nurses cannot diagnose, prescribe medication or give medical advice. Members also may e-mail a nurse by clicking on the "Talk to a Nurse" link on the Aetna member website at www.RCBPhealth.com. Nurses respond to these online member inquiries within 24 hours. The online Healthwise Knowledgebase is an online education support resource available to members through the Aetna member website. It is a user-friendly decision- support tool that provides clinical information on 6,000 health topics, 600 medical tests and procedures, 500 support groups and 3,000 medications. The tool promotes informed health decision-making and helps members learn about their treatment options. Informed Health Line nurses also have access to the Healthwise video library and can relay video links to callers upon request or to provide further education/support of the health topic they discussed.

Special feature	Description
Healthy maternity program	You have access to Aetna's Healthy Maternity Program, which provides educational material and support to pregnant women. Contact Customer Service toll-free at 800-638-8432 for more information.
PinnacleCare	PinnacleCare provides expert medical guidance when you and your covered dependents are faced with a serious or complicated medical condition and might not know where to turn. We are here to help you find the right specialist, get a second opinion, and navigate the medical system. PinnacleCare saves you time and helps you avoid unnecessary medical procedures by making sure you see the right in-network provider, when needed. Our customized services may include: • Expert medical opinion/confirmation of your diagnosis • Research on your diagnosis and treatment options • Customized report identifying top local, regional, or national specialists to fit your needs • Facilitated appointments with top specialists or Centers of Excellence • Gathering, organizing, and forwarding of your key medical records • Virtual consultation for second medical opinion if the specialist you need is out of your area PinnacleCare representatives are available to assist you Monday through Friday 8 a.m. - 6 p.m. (EST) at 888-442-7380 or PinnacleCare.com/support. Let us guide you to the best health care possible.
Complex and Chronic Disease Management Program	Accordant Health Management offers programs for the following complex chronic medical conditions: • Seizure disorders (Epilepsy) • Rheumatoid Arthritis (RA) • Multiple Sclerosis (MS) • Crohn's Disease • Parkinson's Disease (PD) • Systemic Lupus Erythematosus (SLE) • Myasthenia Gravis (MG) • Sickle Cell Disease (SCD) • Cystic Fibrosis (CF) • Hemophilia • Scleroderma • Gaucher Disease • Polymyositis • Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's Disease) • Dermatomyositis • Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP) • Ulcerative Colitis • Human Immunodeficiency Virus (HIV) • Chronic Kidney Disease (CKD) For more information on the Accordant Health Management programs, please call toll-free 866-380-6295.

Special feature	Description
Aetna In Touch Care Program	Aetna In Touch Care (ITC) program offers you: • Ongoing, one-on-one phone calls with a nurse who serves as a trusted resource for you and your family • Digital support that provides a variety of resources to help you better manage your health • Customized health action plans based on your needs and preferences To start using the digital support of Aetna ITC, log in to the Aetna member website. First-time users will need to register, and then go to your health dashboard. We're committed to giving you all the support you deserve. That's why we offer both digital and nurse support, and you can move easily between the two. You'll benefit from many digital health and wellness related programs and resources: • Personal health record–organize and store your health history and information, plus get health alerts and notifications. • Health assessment – get a custom, step-by-step plan based on questions about your health and habits. • Health Decision Support – learn about your health care and treatment options. • Online coaching programs – find dynamic health coaching programs that give you personalized support. • Aetna Health Dashboard–view your health information, and find entry points to health and wellness programs and resources. Aetna ITC Program also includes a Social Work Program designed to improve the quality of life by taking steps to help you locate the right resources. Social workers can help connect you with community resources that can provide services to them in times of need. Some examples include: • Local food pantries • Utility or rental assistance programs • Home-delivered meal services • Support groups • Counseling services Social workers can refer you to Federal and state programs, such as: • Social Security • Medicare • Medicaid Our social workers are licensed and degreed professionals who work in a variety of settings, including government and non-profit organizations, hospitals, schools and clinics. Social workers also help treat mental, emotional, and behavioral issues in clinical settings. **Compassionate Care Program:**

	The Compassionate Care Program is designed to improve the quality of life through health condition management and to reduce costs for you and your family with advanced illness, including those facing imminent end-of-life decisions. It provides tools and information to encourage advance planning for the kind of issues often associated with an advanced illness, such as living wills, advance directives, and tips on how to begin conversations about these issues with loved ones. This program is designed to provide quality of life improvement through health condition management and to reduce costs for you and your family at the end of life through timely member and caregiver education. It encourages better use of community-based services and resources, systemic palliative care integration and enhanced hospice utilization and retention. This program is a voluntary program provided to you and your dependents at no additional cost. If you would like to contact the Plan for more information about the ITC Program, please call 800-638-8432. We are available to assist you Monday-Friday from 6:00 a.m. to 5 p.m. Mountain Time (MST)
Transform Care Programs	The Transform Care Programs for diabetes and hypertension help you stay medication adherent, control your blood glucose and your blood pressure. Participation is voluntary. These programs provide eligible members with a connected glucometer and a digital blood pressure cuff. Digital apps are provided for easier monitoring of your condition. The readings are shared with a health coach that you can interact with through messaging and phone calls. Eligible participants are identified based on their medical history. All eligible members are offered two Minute Clinic visits and unlimited coaching. For questions regarding this program, call 866-623-1441
Lab Savings program	The Lab Savings program gives you the option of having covered outpatient laboratory testing paid at 100%, if your covered provider sends your lab work to Quest Diagnostics or LabCorp for processing. The Lab Savings program 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 Savings program covers most outpatient laboratory testing covered by the Plan provided that the tests are ordered by a covered provider and processed by Quest Diagnostics or LabCorp. Outpatient lab work covered by the Lab Savings 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 Savings program 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 Savings program 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 Savings program services, please call Quest Diagnostics at 800-646-7788 or LabCorp at 888-522-2677 or search for Quest Diagnostics or LabCorp using your zip code in the Plan's online provider search tool website at www.rcbphealth.com.
Pharmacy Advisor Program	If you have one or more of the following chronic conditions, you have the opportunity to discuss one-on-one with a CVS Health pharmacist any questions or concerns about the medication(s) you are taking. Please call toll-free 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
Aetna member website	**Aetna member website - Secure Member Portal** Access the **Aetna member website** by visiting www.RCBPhealth.com, then click on "Aetna member website" under "Member Resources". This provides you secure access to a broad range of your personal health information after you register. **The Aetna member website** provides tools to become an optimal health care consumer. Services such as the following are available: • **Interactive Personal Health Record** — The Plan will build your health record with information from your claims. You also can add other personal health information such as blood pressure, weight, vital statistics, immunization records, and more. • **Claims information** — You can view and organize your claims the way you want: sort by date range, health care provider etc. • **Explanation of Benefits (EOBs)** — You can access and print your EOBs. • **Decision support tools** — You can check the average cost of medical procedures or view hospital quality information before you receive care. • **Health information** — You can obtain health information and news that is relevant to you. • **Interactive health tools** — You can assess, understand, and manage conditions and health risks. Easy to use content helps members navigate common, but sometimes complex conditions. • **KidsHealth Library** — You can access an online resource that educates families and helps them make informed decisions about children's health. KidsHealth is an engaging way to encourage preventive behaviors and motivate kids and teens to become more involved in their health.
Aetna Health App	**After registration/log-in you can use the Aetna Health app to:** - Find doctors and facilities using location and see maps for directions - Locate urgent care - walk in clinics, urgent care, emergency room - View claims and claim details - View benefits and balances - Track out-of-pocket dollars - View ID card information - Store ID card offline - Get cost estimates before you receive care - View your Health History - Share your opinion (feedback) The app can be downloaded for free onto your mobile device. **How to Access:** • Android: Go to Play Store and search for Aetna Health. • iPhone: Go to App Store and search for Aetna Health.

	• Text"**Aetna**" to **90156** to receive a link to download the Aetna Health app (message and data rates may apply) **Supported Devices:** • Android • iPhone®
Wellness Incentive	Members (over 18 years of age) who participate in the plans Wellness Incentive programs can earn up to $250 in rewards per calendar year. Complete the Health Risk Assessment (HRA) and $100 will be deposited in a Wellness Incentive Fund Account to reimburse you for certain unreimbursed medical expenses ("Eligible Medical Expenses"). The questions help you uncover your health risks so you're better able to manage them before they get out of control. Plus, once you take your HRA you receive a personalized health summary to help you better understand your health risks. Complete a biometric screening through Quest Diagnostics by December 1st of the calendar year and $100 will be deposited in a Wellness Incentive Fund Account to reimburse you for certain unreimbursed medical expenses ("Eligible Medical Expenses"). You can obtain the biometric screening at a Quest Diagnostics Patient Service Center (PSC) or you can obtain the screening from your physician by having your physician complete a Biometric Screening Physician Results Form and fax it back to Quest by December 1st of the calendar year. To register for your screening call 855-623-9355 or to print a copy of the Biometric Screening Physician Results Form to take to your physician, visit My.QuestforHealth.com and enter the registration key: RCBP. Once your biometric screening is complete, your results will be available at My.QuestforHealth.com and will also be mailed to you to help you better understand your health risks. Members with the following conditions may be eligible to earn up to $50 for each incentive to be deposited into a Wellness Incentive Account: • **Controlling Blood Pressure for members with high blood pressure**. The Plan will reach out to you if you are identified through claims data as having high blood pressure and will provide you a form for your provider to complete. On the form, your provider must document two (2) controlled blood pressure readings below 140/90 on separate visits during the current calendar year for you to earn the incentive. If you are unable to meet this goal, you will receive the incentive if one of the following is completed: Dietary and nutritional counseling (obtain three counseling visits, which includes individual and group behavioral counseling). See Section 5(a). Telephonic Health Coach Program(Tobacco Cessation, Weight Management, Exercise, Nutrition, Stress Management). • **Controlling A1c Hemoglobin (HbA1c) levels for members with diabetes** The Plan will reach out to you if you are identified through claims data as having diabetes and ask you to have your provider submit your HbA1c laboratory results. Your HbA1c laboratory results must be less than 8% during the calendar year for you to earn the incentive. If your HbA1c is greater than or equal to 8%, you will receive the incentive if one of the following is completed:

Dietary and nutritional counseling (obtain three counseling visits, which include individual and group behavioral counseling). See Section 5(a).

Diabetic Education or Training (see Section 5(a).

Enroll in the Transform Care Programs and check blood glucose using the meter four times per continuous calendar month for four months. **Note: You always should follow directions from your health care provider with respect to the frequency of use and glucose testing.**

Telephonic Health Coach Program (Tobacco Cessation, Weight Management, Exercise, Nutrition, Stress Management).

- **Prenatal Care for members who are pregnant**

  If you are pregnant, your provider must submit documentation of a prenatal care visit during the first trimester. The documentation submitted must include a copy of the prenatal care medical record including Obstetric Panel testing, ultrasound, or prenatal exam from your provider for you to earn the incentive.

- **Eliminating tobacco use for tobacco users**

  If you are identified as a tobacco user you can participate in the Plan's Tobacco Cessation Program (see Section 5(a)). You must complete:

  - At least two quit attempts as part of our Tobacco Cessation Program. The quit attempt must include tobacco cessation counseling sessions of at least 30 minutes each.

Note: To earn the incentive for the conditions outlined above, documentation needs to be mailed by December 1st of the calendar year to: Aetna, C/O FEHB QM, 4400 NW Loop 410, Suite 101, San Antonio, TX 78229.

Eligible Medical Expenses, as defined by Internal Revenue Code Section 213(d), include your deductible, coinsurance, and copayments (e.g., prescription drug copayments) incurred by you or your covered dependents.

Reimbursement for your deductible and coinsurance will be sent to you if there are funds available. Other expenses, like dental, vision, and prescriptions purchased through the Plan's retail pharmacy network or mail order program cannot be reimbursed automatically. You will need to submit a copy of your receipt with a completed claim form (*Wellness Incentive Claim Form*) found on the Aetna member website.

- Visit RCBPhealth.com
- Select "**Official Plan Documents**" under "**Member Resources**"
- Select "**Wellness Incentive Claim Form**"

If you are enrolled in a Flexible Spending Account (FSA) and wellness incentives have been deposited into your wellness fund, you may not receive reimbursement for the same medical expense from both your wellness fund account and your FSA. If a medical expense is covered under both your wellness fund account and your FSA, you must use the funds in your wellness fund account first. Enrollees may receive reimbursements from their FSAs for medical expenses that are covered by both their wellness fund account and their FSA only after the funds in the wellness fund account have been exhausted. In order to receive reimbursement from your wellness fund account for qualified medical expenses, you must complete and sign a *Wellness Incentive Claim Form* certifying that you have not received reimbursement for the applicable qualified medical expense and that you will not seek such reimbursement under any other plan or arrangement. If you receive reimbursements from more than one plan or arrangement for the same qualified medical expense, the amount received in excess of the qualified medical expense may be taxable to you as income.

	To monitor the availability of funds in your Wellness Incentive Fund Account, visit the Plan's website (www.RCBPhealth.com), and then click on "Aetna member website". Once you log on to the Aetna member website, look for the "Health and Wellness" icon, click "Discover a Healthier You" and proceed. After you have completed a wellness activity, the Plan will deposit the amount earned into a Wellness Incentive Fund Account. Please allow at least 4 weeks after completing a wellness activity for incentives earned to be deposited in the Wellness Incentive Fund Account. You will be reimbursed for certain unreimbursed medical expenses such as deductible, coinsurance, copays and other "Eligible Medical Expenses" approved by the IRS. If you have any questions or would like more information about the program, please call customer service at 800-638-8432.
Comprehensive Pain Management Program	RCBP has initiated a Comprehensive Pain Management program to combat the spectrum of chronic pain to acute pain for our members. RCBP members suffer a high incidence of pain largely due to the aging population and the repetitive motion demands of their jobs. Three out of four RCBP members have received a diagnosis for a specific musculoskeletal issue over the past three years which is the tip of the spear for the member's physical suffering and the fiscal burden on RCBP members. A Comprehensive Pain Management Program is needed to help our members dealing with chronic pain management to help them increase their mobility, decrease opioid dependency, improve their quality of life and to help ward off secondary anxiety and depression that often accompanies unchecked long-term pain. RCBP is leveraging multiple vender partners to provide theinfrastructureand process for a successful pain program. RCBP's partner, TrestleTree,is collaborating and coordinating with Aetna and CVS Health to help facilitate a multi-pronged identification and engagement strategy into TrestleTree's behavior change pain management program. Aetna's case managers are currently handing-off at-risk members to TrestleTree's Coaches and CVS Health is providing a daily Rx file feed directly to TrestleTree to identify each member that had an opioid or pain management medication filled the previous day. Want more information about the Comprehensive Pain Management Program? Contact TrestleTree directly at 855-553-5109. We also have an Opioid Support Program through TrestleTree. See elsewhere in this Section under Telephonic Health Coaching Program.
Telephonic Health Coach Program	The Telephonic Health Coach program provides you and your covered dependents the opportunity to work one-on-one with a Health Coach to improve your health. A Health Coach is a healthcare professional who partners with you to transform your health goals into action. Your Health Coach will provide guidance, support, and resources to help you overcome obstacles that may be keeping you from realizing optimal health. You can talk to a Health Coach about the following health-related matters: • Tobacco Cessation • Weight Management • Exercise • Nutrition • Stress Management • Opioid Support Program **How does health coaching work?** • You talk with your Health Coach over the phone through conveniently scheduled appointments and create a plan that is right for you to meet your health goals. Everything in the program is tailored to you.

	• You explore ways to make changes in your behavior that will last. • You receive written materials from your Health Coach that can help you decide where you want to go with your health and how to get there. • Appointments can range from 15 minutes to 30 minutes once a month or twice a month. How long and how often you meet with your Health Coach depends on your individual needs. To enroll in a program, contact a Health Coach at 855-553-5109. Coaches are available Monday through Thursday from 8:00 a.m. – 10:00 p.m. ET and Friday from 8:00 a.m. – 6:00 p.m. ET. You may also enroll online at enroll.trestletree.com (passcode: RCBP). Note: See Section 5(a), Educational classes and programs for more information.
Health Risk Assessment	Make a difference in your health in just a few minutes by completing a simple Health Risk Assessment (HRA). It asks questions about your health history and habits. It can: • Help you learn more about your health risks, so you can take steps to lower them • Provide strategies to improve your health and well-being • Give you personalized health results to share with your doctor To schedule an appointment to complete your telephonic HRA, contact a Health Coach at 855-553-5109. Coaches are available Monday through Thursday from 8:00 a.m. – 10:00 p. m. ET and Friday from 8:00 a.m. – 6:00 p.m. ET. You can also schedule an appointment online at http://enroll.trestletree.com (passcode: RCBP).
Telehealth	Our telehealth vendor, DialCare can be used any time, day, or night. It's perfect when your doctor's office is closed, you're too sick or busy to see someone in person, or even when you're traveling and it costs you $0 per visit. It's easy to use, private, and secure. DialCare offers: • Doctors or mental health professionals who are licensed in your state • Telephonic or video visits using the web or mobile app • Consultations that are private, secure and HIPPA-compliant DialCare is easy to access: • Download the mobile app or register at dialcare.com/verify • Once registered, you can request consults with physicians or mental health professionals both through the app or through member.dialcare.com • For assistance signing up, call DialCare at **855-335-2255**
AbleTo Support Program	AbleTo is a web-based video conferencing personalized 8-week treatment support designed to address the unique emotional and behavioral health needs of individuals learning to live with conditions like heart disease, type 2 diabetes, chronic pain or life events like losing a loved one or having a baby. Members work with the same therapist and coach each week to set reasonable goals toward healthier lifestyle changes. There are several ways we identify members that may benefit from the AbleTo support such as: • Your nurses or clinicians may refer you to AbleTo as they work directly with you and can refer you if it's determined that you can benefit from AbleTo • If identified, an Engagement Specialist from AbleTo will contact you to introduce the treatment

	If you feel you would benefit from this program, would like more information, or enroll in this program please call 866-287-1802 or visit their website at www.AbleTo.com/enroll.
Value Added Programs and Services	The Plan may offer a number of programs and services to members to maximize optimal health, reduce out of pocket costs, and assist with special conditions and needs as they become available during the year. Visit www.rcbphealth.com for a current list of programs, program criteria, and contact information.
Sleepio	Sleepio is an online sleep improvement program that is scientifically proven to work. Sleepio teaches you how to fall asleep faster, stay asleep during the night and feel better during the day, even if you have had trouble sleeping for months or years. You'll start by taking this quick sleep quiz at www.sleepio.com/RCBP, which will provide you with your Sleep Score and a personalized tip you can try tonight to improve your sleep. Then, using the online sessions, you will learn a range of science-backed cognitive and behavioral techniques that are proven to help you sleep better. These techniques will help you establish a healthy sleep pattern, addressing the mental factors associated with sleep problems such as the 'racing mind', so you can overcome the worry and other negative emotions that come with being unable to sleep. By developing a 'pro-sleep' routine to achieve a strong connection between bed and sleep, falling asleep (and staying asleep) becomes more automatic and natural. Each online session takes about 20 minutes to complete and is tailored to improve your specific sleep habits and help you reach your sleep goals. Between sessions, you will complete a daily Sleep Diary to track your progress and receive reminders to help you stick with the program. Join Sleepio's supportive online community where you can read articles on topics like pregnancy and sleep, shift work, jet lag and menopause. Start by discovering your Sleep Score in two minutes at www.sleepio.com/RCBP.
Digital (online) Coaching Program	Digital coaching programs — These include nine base programs for weight management, smoking cessation, stress management, nutrition, physical activity, cholesterol management, blood pressure, depression management, and sleep improvement. Programs are prioritized based on a member's health risk assessment to help create a personalized plan for successful behavior change. Members can engage and participate through personalized messaging with tools and resources to help track their progress and stay on the path to wellness. This provides you secure access to a broad range of your personal health information after you register. Access the Plan's website tool from your Aetna member website at www.rcbphealth.com. Select "Discover a Healthier You" under the Stay Healthy icon, then "Dashboard" and finally "Digital Coach".

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 a 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 703-684-5552 or visit their website at www.nrlca.org.

TruHearing -- RCBP members can save 30 percent to 60 percent off the average retail price of hearing aids with TruHearing, making it affordable to address your hearing needs.

TruHearing offers a selection of more than 100 of the latest hearing aids from the top hearing aid manufacturers in the world. A TruHearing provider in your area can give you a hearing exam and recommend the right hearing aids for your lifestyle and budget.

When you use TruHearing, you also get:

- Three follow-up visits with a provider for fitting and adjustments;
- 45-day money-back guarantee;
- Three-year manufacturer's warranty for repairs and one-time loss and damage replacement;
- 48 free batteries per aid.

TruHearing discounts are available to all RCBP members and their families, including over-age children, domestic partners, same-sex spouses, parents and grandparents. If you think you or a loved one may benefit from hearing aids, call TruHearing at 844-341-9730 to get the right hearing aids at a price you can afford.

EyeMed Vision Care Program -- Save up to 35% 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 31,000 providers including optometrists, ophthalmologists, and opticians and leading optical retailers such as: LensCrafters, participating Pearle Vision and Sears Optical locations, Target Optical, JCPenney Optical and many independents.

Save 15% of standard prices or 5% off promotional prices for LASIK services obtained through the U.S. Laser Network. Call U.S. Laser Network customer service at 800-422-6600 to get started.

For more information concerning the program or to locate a participating provider, visit the Plan's website at www.RCBPhealth.com and select Aetna member website, then Discounts under the Health and Wellness icon, then Vision or call toll-free 800-638-8432.

ExtraCare Health Card-- Plan members receive the ExtraCare Health Card from CVS Health. This consumer-friendly program is designed to increase satisfaction and provide savings to Plan members and their families at over 7,700 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
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 but not limited to: transplants, radiology imaging procedures, radiation oncology, inpatient and skilled nursing facility admissions, mental health and substance abuse treatment, and certain prescription drugs, (see Section 3 *When you need prior Plan approval for certain services under Other 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 sexual dysfunction or impotence;
- Services, drugs, or supplies you receive from a provider or facility barred or precluded from the FEHB or other Federal Programs; or
- Services, drugs, or supplies you receive without charge while in active military service;
- Services, drugs, or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage, or adoption;
- Services, drugs, or supplies furnished 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 89), 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 89) or State premium taxes however applied;
- Custodial care;
- Counseling, therapy, or treatment for marital, educational, sexual paraphilias, or behavioral diagnoses/problems; or related to mental retardation, or learning disorders/disabilities as listed in the most recent edition of the International Classification of Diseases (ICD);
- 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 except as described in Section 5(a) under Nutritional Counseling;
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction (except for biofeedback under Section 5(a), Treatment Therapies) 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 phone consultations, conferences, or treatment by phone, mailings, faxes, e-mails or any other communication to or from a hospital or covered provider except as described under Section 5(a), Medical services and supplies;
- Hypnotherapy, and milieu therapy;
- Biofeedback except as described in Section 5(a), *Treatment therapies*;
- Preventive medical care and services, except those provided under Preventive care adult and Preventive care children in Section 5(a);
- Private duty nursing care;
- 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 800-638-8432 or at our website at www.rcbphealth.com.

In most cases, providers and facilities file claims for you. Your provider 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 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 14079
Lexington, KY 40512-4079

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.
- Claims for rental or purchase of durable medical equipment must include the price of the equipment, a prescription and a written statement from the provid specifying the medical necessity, including the diagnosis, and the estimated length of time needed.
- 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 Section 5(f), Prescription drug benefits for instructions on how to file a claim for prescription drugs that you buy at a non-participating (out-of-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 must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on 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. We will use the U.S. dollar exchange rate applicable on the date service was incurred if you do not supply us with a currency exchange rate along with a paid receipt. Overseas providers (those outside the 50 United States) will be paid at the In-Network level of benefits for covered services. Overseas hospitals and physicians are under no obligation to file claims for you. **You may be required to pay for the services at the time you receive them and then submit a claim to us for reimbursement.**
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 phone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language. Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes and its corresponding meaning, and the treatment code and its corresponding meaning).

Section 8. The Disputed Claims Process

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

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, 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 14079, Lexington, KY 40512-4079 or calling toll-free 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.

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

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

We will not make our 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 14079, Lexington, KY 40512-4079; 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, FEHB 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 file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-638-8432. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 2 at 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 our website at www.rcbphealth.com.

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: The $200 deductible for prescriptions purchased at a network retail pharmacy does not apply when you have Medicare Parts A and B as primary coverage.

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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage. By accepting Plan benefits, you agree to the terms of this provision.

If you have received benefits or benefit payments as a result of an injury or illness, and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. The Plan's right of reimbursement extends to all benefit payments for related treatment incurred up to and including the date of settlement or judgement, regardless of the date that those expenses were submitted to the Plan for payment

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" or any other doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

Examples of situations to which our reimbursement and subrogation rights apply include, but are not limited to, when you become ill or are injured due to (1) an accident on the premises owned by a third party, (2) a motor vehicle accident, (3) a slip and fall, (4) an accident at work, (5) medical malpractice, or (6) a defective product.

Our reimbursement and subrogation rights extend to all benefits available to you under any law or under any type of insurance or benefit program, including but not limited to:

- No-fault insurance and other insurance that pays without regard to fault, including personal injury protection benefits, regardless of any election made by you to treat those benefits as secondary to us. When you are entitled to payment of healthcare expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payor and we are the secondary payor;
- Third party liability coverage;
- Personal or business umbrella coverage;
- Uninsured and underinsured motorist coverage;
- Workers' Compensation benefits;
- Medical reimbursement or payment coverage;
- Homeowners or property insurance;
- Payments directly from the responsible party, and
- Funds or accounts established through settlement or judgment to compensate injured parties

You agree to cooperate with our enforcement of our reimbursement right by:

- Telling us promptly whenever you have filed a claim for compensation resulting from an accidental injury or illness and responding to our questionnaires;
- Pursuing recovery of our benefit payments from the third party or available insurance company;
- Accepting our lien for the full amount of our benefit payments;
- Signing our Reimbursement Agreement when requested to do so;
- Agreeing to assign any proceeds or rights to proceeds from third party claims or any insurance to us;
- Keeping us advised of the claim's status;
- Agreeing and authorizing us to communicate directly with any relevant insurance carrier regarding the claim related to your injury or illness;
- Advising us of any recoveries you obtain, whether by insurance claim, settlement or court order; and
- Agreeing that you or your legal representative will hold any funds from settlement or judgment in trust until you have verified our lien amount, and reimbursed us out of any recovery received to the full extent of our reimbursement right.

You further agree to cooperate fully with us in the event we exercise our subrogation right.

Failure to cooperate with these obligations may result in the temporary suspension of your benefits and/or offsetting of future benefits.

For more information about this process, please call our Third Party Recovery Services unit at 202-683-9140 or 855-661-7973 (toll free). You also can email them at info@elgtprs.com.

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 or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical trials

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

If you are a participant in a clinical trial, this 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

For more detailed information on "What is Medicare?" and "Should I Enroll in Medicare?" please contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

- **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 800-MEDICARE 800-633-4227, TTY: 877-486-2048 for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage Plan to get your Medicare benefits. Please review the information on coordinating benefits with Medicare Advantage Plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 800-772-1213, TTY: 800-325-0778.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 800-772-1213, TTY: 800-325-0778 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. 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 did not take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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

(Please refer to page 98 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 misuse disorder 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 800-638-8432.

We waive some costs if the Original Medicare Plan is your primary payor – Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. If you purchase Medicare Part B, your provider is in our network and participates in Medicare, then we waive some costs because Medicare will be the primary payor.

Benefit Description	High Option You pay without Medicare		High Option You pay with Medicare	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	$350/$700	$800/$1600	N/A	N/A
Catastrophic Protection Out of pocket maximum	$5,000/$10,000	$7,000/$14,000	$5,000/$10,000	$7,000/$14,000
Part B premium reimbursement offered	N/A	N/A	N/A	N/A
Primary care physician	$20 copay	30% of Plan allowance and any difference after deductible	Nothing	Nothing
Specialist	$35 copay	30% of Plan allowance and any difference after deductible	Nothing	Nothing
Inpatient hospital	$200 copay per admission	$400 copay per admission and any difference after deductible	Nothing	Nothing
Outpatient hospital	15% of Plan's allowance after calendar year deductible	30% of Plan allowance and any difference after calendar year deductible	Nothing	Nothing
Incentives offered	N/A	N/A	N/A	N/A

Note: The $200 deductible for prescriptions purchased at a network retail pharmacy does not apply when you have Medicare Parts A and B as primary coverage.

- **Tell us about your Medicare coverage**

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

- **Private Contract with your physician**

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

- **Medicare Advantage (Part C)**

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

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

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. However 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.
Does not participate with Medicare and is not a member of our PPO network,	your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount.
Opts-out of Medicare via private contract,	your deductibles, coinsurance, copayments, and any balance your physician charges.

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

Physicians Who Opt-Out of Medicare

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

Our explanation of benefits (EOB) 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, you pay nothing for covered charges.
- If your physician does not accept Medicare assignment, 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. These costs are generally covered by the clinical trials. This plan does not cover these costs.

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 20.

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 Minute Clinic 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 20.

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 20.
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.
Genetic screening	The diagnosis, prognosis, management, and prevention of genetic disease for those patients who have no current evidence or manifestation of a genetic disease and those who we have not determined to have an inheritable risk of genetic disease.
Genetic testing	The diagnosis and management of genetic disease for those patients with current signs and symptoms and for those who we have determined to have an inheritable risk of genetic disease.
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.
Infertility	The inability to conceive after 12 months of unprotected intravaginal sexual relations (or 12 cycles of artificial insemination) for women under age 35, and 6 months of unprotected intravaginal sexual relations (or 6 cycles of artificial insemination) for women age 35 and over.
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 foods

A medical food, as defined by the Orphan Drug Act (21 U.S.C. 360ee (b) (3)) is a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. In general, to be considered a medical food, a product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for the dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; and the product must be intended to be used under medical supervision.

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.

Mental health conditions/ substance use disorder

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as mental, behavioral, and neurodevelopmental disorders, to be determined by the Plan.

Observation Care

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are provided while a decision is being made regarding whether a patient will require further treatment as a hospital inpatient or whether the patient will be able to be discharged from the hospital. Observation services are commonly ordered for a patient who presents to the emergency room department and who then requires a significant period of treatment or monitoring in order to make a decision regarding their inpatient admission or discharge. Some hospitals will bill for observation room status (hourly) and hospital incidental services.

If you are in the hospital for more than a few hours, always ask your physician or the hospital staff if your stay is considered inpatient or outpatient. Although you may stay overnight in a hospital room and receive meals and other hospital services, some hospital services-including “observation care”- are actually outpatient care. Since observation services are billed as outpatient care, outpatient facility benefit levels apply and your out-of-pocket expenses may be higher as a result.

This Plan uses National Standardized Criteria Sets and other recognized clinical guidelines in making determinations to evaluate the appropriateness of observation care services.

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.

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, 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 prescription medications is based on the average wholesale price or an alternative pricing benchmark.

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.

Reimbursement

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

Routine preventive services/immunizations

Preventive services:

- We cover preventive services, counseling and screenings recommended under the Affordable Care Act (ACA). For a complete list of ACA preventive care services, visit: www.healthcare.gov/what-are-my-preventive-care-benefits. We cover preventive services, counseling and screenings that that have a recommendation of "A" or "B" from the United States Preventive Services Task Force (USPSTF). For a complete list of preventive care services with an "A" or "B" recommendation by the USPSTF visit www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. If our preventive services, counseling and screening benefits are more generous than the ACA or USPSTF "A" or "B" recommendations, we pay under the appropriate benefit without cost sharing when delivered by an in-network provider.

Immunizations:

- We cover routine adult immunizations. See www.cdc.gov/vaccines/schedules/index.html.

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

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

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

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

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

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 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.

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- 2021

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this FEHB brochure. You can obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act Summary at www.rcbphealth.com. 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/$800 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 primary care provider:** $20/ office visit **In-network specialist provider:** $35/office visit	29-30
• Surgery	**Out-of-network:** 30% of our allowance and any difference between our allowance and the billed amount* **In-network:** 15% of our allowance (No deductible) **Out-of-network:** 30% of our allowance and any difference between our allowance and the billed amount	48-52
• Telehealth	**In-network:** Nothing (No deductible) if you contact DialCare for services. **Out-of-network:** No benefit.	31
Services provided by a hospital:		
• Inpatient	**In-network:** $200 copayment per admission (waived for maternity stay) **Out-of-network:** $400 copayment per admission; 30% of covered charges **In-network:** 15% of our allowance* **Out-of-network:** 30% of our allowance* and any difference between our allowance and the billed amount	59-61
• Outpatient		61
Emergency benefits:		

High Option Benefits	You pay	Page
• Accidental injury	Nothing for emergency room visit and first physician office visit	64
• Medical emergency	Emergency room benefits for **In-network** and **Out-of-network** services: 15% of the Plan allowance*	65
Mental health and substance use treatment:		
• Applied Behavioral Analysis (ABA)	**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	67
• Inpatient	**In-network:** $200 copayment per admission **Out-of-network:** $400 copayment per admission; 30% of covered charges.	68
• Outpatient	**In-network:** 15% of the Plan allowance* **Out-of-network:** Physician Services--30% of the Plan allowance and any difference between our allowance and the billed amount* **Facility Chargers:**--30% of the Plan allowance and any difference between our allowance and the billed amount*	69
Prescription drugs:		
• Network and Non-Network pharmacy	30% of cost*	73-74
• Mail order pharmacy	Up to a 90 day supply: Tier I--$10/generic; Tier II--$50/preferred brand name; Tier III--$80/non-preferred brand name; Tier IV--Specialty drugs $80 for a 30 day supply/$125 for a 90 day supply	74
• Mail order pharmacy with Medicare Part B	Up to a 90 day supply: Tier I--$10/generic; Tier II--$40/preferred brand name; Tier III--$70/non-preferred brand name: Tier IV--Specialty drugs $80 for a 30 day supply/$125 for a 90 day supply	74
Dental care:	Any difference between our scheduled allowance and the billed amount	77-78
Special features:		79-89

	Flexible benefits option; Cancer treatment benefit; Kidney dialysis benefit; 24 hour nurse line; Travel assistance program; Routine eye exam benefit; Healthy maternity program; Complex and Chronic Disease Management Program; Aetna In Touch Care Program; Livongo, a remote diabetes monitoring program; Lab Savings program; Smoking cessation program; Institutes of Excellence (IOE); Genetic testing for prescription drugs; Pharmacy Advisor Program; Wellness Incentive program; Health Risk Assessment; Telephonic Health Coaching program; Telehealth program	
Protection against catastrophic costs (out-of-pocket maximum)**:**	**In-network:** Nothing after $5,000 for Self Only enrollment or $10,000 for Self Plus One or Self and Family enrollment per calendar year including CVS Health In-network retail and/or mail service pharmacy. **Out-of-network:** Nothing after $7,000 for Self Only enrollment or $14,000 for Self Plus One or Self and Family per calendar year including CVS Health In-network retail and/or mail service pharmacy. Note: Benefit maximums apply and some costs do not count toward this protection	25

Notes

2021 Rate Information for Rural Carrier Benefit Plan

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

To review premium rates for all FEHB health plan options please go to

www.opm.gov/FEHBpremiums or **www.opm.gov/Tribalpremium.**

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

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

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreement: NALC.
- **Postal Category 2** rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and and career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NPMHU, NPPN and NRLCA. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

USPS Human Resources Shared Service Center: 1-877-477-3273, option 5, Federal Relay Service 1-800-877-8339

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Nationwide							
High Option Self Only	381	$241.58	$126.72	$523.42	$274.56	$123.36	$113.30
High Option Self Plus One	383	$517.46	$226.75	$1,121.16	$491.30	$219.56	$198.00
High Option Self and Family	382	$562.25	$219.46	$1,218.21	$475.50	$211.65	$188.23