

Rural Carrier Benefit Plan

www.rcbphealth.com

Customer Service 800-638-8432



2024

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 8 for details. This plan is accredited. See Section 1, How This Plan Works.

IMPORTANT

- Rates: Back Cover
- Changes for 2024: Page 16
- Summary of Benefits: Page 126

Sponsored 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

Authorized for distribution by the:



United States
Office of Personnel Management

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

RI 72-005

**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 your FEHB plan will coordinate benefits with Medicare.

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

Please be advised

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

Medicare's Low Income Benefits

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

Potential Additional Premium for Medicare's High Income Members

Income-Related Monthly Adjustment Amount (IRMAA)

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you may pay in addition to your FEHB premium to enroll in and maintain Medicare prescription drug coverage. **This additional premium is assessed only to those with higher incomes and is adjusted based on the income reported on your IRS tax return.** You do not make any IRMAA payments to your FEHB plan. Refer to the Part D-IRMAA section of the Medicare website: www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to this additional premium.

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

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

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Introduction

This brochure describes the benefits of the Rural Carrier Benefit Plan under contract (CS 1073) between The National Rural Letter Carriers' Association and 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, 2024 unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates for each Plan annually. Benefit changes are effective January 1, 2024 and changes are summarized on page 16. 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 Healthcare Fraud!

Fraud increases the cost of healthcare 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 healthcare provider, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using healthcare 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 HEALTHCARE 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 they were 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 health benefits described in this brochure are consistent with applicable laws prohibiting discrimination.

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 healthcare 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 healthcare 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 healthcare 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 healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.

- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare 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 healthcare 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)** Coverage under this plan qualifies as minimum essential coverage. 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, give you other plans' brochures and materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

We do not 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, disability leave, pensions, etc, you must also contact your employing or retirement office.

Once enrolled in your FEHB Program Plan, you should contact your carrier directly for updates and questions about your benefit coverage.

- **Enrollment types available for you and your family** Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include 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.

Contact your employing or retirement office if you want to change from Self Only to Self Plus One or Self and Family. If you have a Self and Family enrollment, you may contact us to add a family member.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26. We will send a written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before 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 your spouse by valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

Natural children, adopted children, and stepchildren

Coverage: Natural children, adopted children, and stepchildren are covered until their 26th birthday.

Foster children

Coverage: Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.

Children incapable of self-support

Coverage: 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

Coverage: 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

Coverage: 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 applies 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 2024 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 2023 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 an enrollee, and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must contact us to let us know the date of the divorce or annulment and have us remove your ex-spouse. We may ask for a copy of the divorce decree as proof. In order to change enrollment type, you must contact your employing or retirement office. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member 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/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you 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). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn 26, regardless of marital status, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. 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 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.

- **Converting to individual coverage**

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

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, a waiting period will not be imposed, and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 800-638-8432 or visit our website at www.rcbphealth.com

- **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 healthcare 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 healthcare 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.rcbphhealth.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.

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 healthcare 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 healthcare 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 they are participating in the Aetna Choice POS II network.
- Present your Rural Carrier Benefit Plan Identification (ID) Card at the time you visit your healthcare 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.
- 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 healthcare 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.rcbphhealth.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.

- Rural Carrier Benefit Plan has been a plan offering since 1960
- The National Rural Letter Carriers' Association (NRLCA) is a non-profit entity

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 healthcare. You can understand your rights and responsibilities for your own healthcare 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 healthcare provider
- Tell your healthcare provider about any living will, durable medical power of attorney or other healthcare directive that could affect your care
- Treat your healthcare provider with respect
- Follow the treatment plan prescribed by your healthcare 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 2024

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, and decrease for Self Plus One and Self and Family coverage. See back cover: *2024 Rate Information*.
- The Plan updated our prior approval list, see Section 3, *How You Get Care*.
- The Plan enhanced our covered infertility benefits, see Section 5(a), *Infertility services* and Section 5(f), *Prescription Drug Benefits*.
- The Plan updated our Telephonic Health Coach Program, see Section 5(a), *Educational classes and programs* and Section 5 (h), *Telephonic Health Coach Program*.
- The Plan modified the Site of Care Management Program for specialty medications, see Section 5(f), *Prescription Drug Benefits*.
- The Plan modified our prescription drug benefits, see Section 5(f), *Prescription Drug Benefits*.
- The Plan added a Part D SilverScript Employer Prescription Drug Plan (PDP), see Section 5(f), *Prescription Drug Benefits* and Section 9, *Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)*.
- The Plan changed our Wellness Incentive program, see Section 5(h), *Wellness Incentives*.
- The Plan modified our Healthy Maternity Program, see Section 5(h), *Healthy Maternity Program*.
- The Plan added LabCorp as an option for obtaining your Biometric Screening, see Section 5(h), *Wellness and Other Special Features*.
- The Plan removed the AbleTo Support Program.
- The Plan removed the Sleepio Program.
- The Plan removed the PinnacleCare Program.
- The Plan has updated our list of not covered services, see Section 6, *General Exclusions*.

Clarifications to this Plan

- The Plan clarified services covered under Gene-Based Cellular and other Innovative Therapies (GCIT™), see Section 5(a), *Treatment therapies* and Section 5(c), *Outpatient hospital or ambulatory surgical center*.
- The Plan clarified that breastfeeding supplies are covered, see Section 5(a), *Maternity care*.
- The Plan clarified the catastrophic out-of-pocket maximum is changing for our Aetna Medicare Advantage for Rural Carrier Benefit Plan members, see Section 9, *Coordinating Benefits with Medicare and Other Coverage*.

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.rcbphhealth.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

Covered 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 healthcare services in the normal course of business. Covered services must be provided in the state in which the practitioner is licensed or certified.

Benefits are provided under this Plan for the services of covered providers, in accordance with 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.

We list network-contracted covered providers in our network provider directory, which we update periodically, and make available on our website.

This plan recognizes that transgender, non-binary, and other gender diverse members require health care delivered by healthcare providers experienced in gender affirming health. Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex or gender.

This plan provides Care Coordinators for complex conditions and can be reached at 800-638-8432 for assistance.

• 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.

Birth 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.

Balance Billing Protection

FEHB Carriers must have clauses in their in-network (participating) providers agreements. These clauses provide that, for a service that is a covered benefit in the plan brochure or for services determined not medically necessary, the in-network provider agrees to hold the covered individual harmless (and may not bill) for the difference between the billed charge and the in network contracted amount. If an in-network provider bills you for covered services over your normal cost share (deductible, copay, co-insurance) contact your Carrier to enforce the terms of its provider contract.

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:

- Ambulance – prior approval required for transportation by fixed-wing aircraft (plane)
- Autologous chondrocyte implantation, Carticel
- BRCA genetic testing
- Cardiac rhythm implantable devices

- 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
- Comprehensive Infertility and Advance Reproductive Technology (ART)
- 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 or implantation
- Electric or motorized wheelchairs and scooters
- Endoscopic nasal balloon dilation procedures
- Gender affirming surgery, even if outside of the 50 United States
- Gene therapy, gene editing and gene silencing
- Hip and knee arthroplasties
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- 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)
- Lower limb prosthetics
- Observation stays 24 hours or more
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)
- Out-of-network freestanding ambulatory surgical facility services, when referred by an in-network provider
- Osseointegrated implant
- Osteochondral allograft/knee
- Pain Management
- Pediatric Congenital Heart Surgery
- Polysomnography (attended sleep studies)
- Proton beam radiotherapy
- Radiation oncology
- 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
- Shoulder arthroplasty
- Specialty medications*
- Spinal procedures, such as:
 - Artificial intervertebral disc surgery

- Cervical, lumbar and thoracic laminectomy/laminotomy procedures
- Sacroiliac joint fusions
- Spinal fusion surgery
- Vertebral corpectomy
- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices

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.

*Note: Some specialty medications must be dispensed through CVS Specialty Pharmacy and requires prior authorization. See Section 5(f), *Prescription drug benefits*. Call CVS Specialty Pharmacy Services at 866-814-5506 to obtain prior authorization.

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 hospital stay, the newborn is considered a patient in their 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 your claim is in reference to a contraceptive, call us at 800-292-4182.

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 healthcare 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.

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 visit 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. The \$400 does not apply to out-of-network hospital stays for mental health and/or substance use disorders.

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 (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 the 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 the 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 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 following shows the amount you pay if you have met your calendar year deductible.

EXAMPLE

Network physician

Physician's charge: \$150
Our allowance: We set it at \$100
We pay: 85% of our allowance: \$85
You owe: Coinsurance: 15% of our allowance: \$15
+ Difference up to charge? No; \$0
Total You Pay: \$15

Out-of-network physician

Physician's charge: \$150
Our allowance: We set it at \$100
We pay: 70% of our allowance: \$70
You owe: Coinsurance: 30% of our allowance: \$30
+Difference up to charge? Yes; \$50
Total You Pay: \$80

You should also see this section under *Important Notice About Surprise Billing - Know Your Rights* that describes your protection against surprise billing under the No Surprises Act.

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 maximum. 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.

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.

Important Notice About Surprise Billing - Know Your Rights

The No Surprises Act (NSA) is a federal law that provides you with protections against "surprise billing" and "balance billing" for out-of-network emergency services; out-of-network non-emergency services provided with respect to a visit to a participating health care facility; and out-of-network air ambulance services.

A surprise bill is an unexpected bill you receive for

- emergency care – when you have little or no say in the facility or provider from whom you receive care, or for
- non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for
- air ambulance services furnished by nonparticipating providers of air ambulance services.

Balance billing happens when you receive a bill from the out-of-network provider, facility, or air ambulance service for the difference between the out-of-network provider's charge and the amount payable by your health plan.

Your health plan must comply with the NSA protections that hold you harmless from surprise bills. Any claims subject to the No Surprises Act will be paid in accordance with the requirements of such law. Aetna will determine the rate payable to the out-of-network provider based on the median in-network rate or such other data resources or factors as determined by Aetna. Your cost share paid with respect to the items and services will be based on the qualifying payment amount, as defined under the No Surprises Act, and applied toward your in-network deductible (if applicable) and out-of-pocket maximum.

Please note: there are certain circumstances under the law where a provider can give you notice that they are out of network and you can consent to receiving a balance bill.

For specific information on surprise billing, the rights and protections you have, and your responsibilities go to www.rcbphealth.com or contact the health plan at 800-638-8432.

**The Federal Flexible
Spending Account
Program- *FSAFEDS***

- **Healthcare FSA (HCFSA)** – Reimburses you for eligible out-of-pocket healthcare 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 5. High Option Benefits

See page 16 for how our benefits changed this year. Pages 126 - 128 are a benefits summary of the high option.

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Section 5. High Option Benefits Overview

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 800-638-8432 or visit our website at www.rcbphealth.com.

The RCBP High Option provides a wide range of comprehensive benefits for preventive services, doctors' visits and services, care in a hospital, laboratory tests and procedures, accidental and emergency services, mental health and substance use disorder treatment and prescription drugs. We have an extensive provider network for both medical and mental health services to help lower your costs, however you may use any provider you wish, in or out of our network.

RCBP High Option includes:

Preventive care

The Plan provides an extensive range of preventive benefits to help members stay well. We include 100% coverage for a variety of in-network preventive tests and screenings, routine physical exams, and tobacco cessation. To keep children well, we provide 100% coverage for recommended well child visits, immunizations, and physical exams. We also cover women's wellness at 100% for a full range of in-network preventive services, preventive tests and screenings and counseling services. We also cover certain medications and supplements to prevent certain health conditions for adults, women and children as recommended by the Affordable Care Act (ACA).

Medical and Surgical services

The Plan provides coverage for doctors' visits and surgical services and supplies. You pay only a flat copayment for office visits to a network physician. In-network maternity care is covered 100%, including breastfeeding support. We provide the same standards for behavioral health services as for medical and surgical care.

Hospitalization and Emergency care

We offer extensive benefits for hospital and other inpatient healthcare services. There is no deductible for in-network hospital care. The Plan provides 100% coverage for accidental injury.

Prescription drugs

Our prescription drug program offers prescription savings with no deductible and low copayments for drugs filled through our CVS Caremark mail service program. The prescription drug program includes a broad network of pharmacies and a mail order service program that delivers your medications right to your door.

RCBP's member website gives you direct access to the following member tools, resources and additional programs:

- Cost of care tools that allow you to compare estimates for medical services and compare hospital facility rates.
- Rx drug calculator tool that allows you to check formulary and pricing information at retail vs. mail service for both the brand and generic, if available.
- Real-time, out-of-pocket estimates for medical expenses based on your RCBP health plan. You can compare the cost of doctors and facilities before you make an appointment, helping you budget for and manage healthcare expenses.
- A hospital comparison tool that allows you to see how hospitals in your area rank on measures important to your care.
- Our online directory of participating physicians, hospitals and other healthcare providers. Search results include patient ratings and reviews.
- Online customer service that allows you to request member ID cards, send secure messages to Member Services, and more.

We also offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members who have primary Medicare Parts A and B. Enrollment in the Aetna Medicare Advantage Plan is voluntary and at no additional cost to you. Members may opt in or out of the Plan at any time. Members have access to a nationwide provider network and may seek care in or out of network. Members who are enrolled in Aetna Medicare Advantage and Rural Carrier Benefit Plan will have access to certain benefit enhancements as noted in Section 9. For more information call us at 866-241-0262 or go to www.aetnaretireehealth.com/rcbp

**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.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).
- 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.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of \$75 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

Benefit Description	You Pay
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Diagnostic and treatment services	High Option
<p>Professional services of physicians, telehealth consultations (except surgery)</p> <ul style="list-style-type: none"> • 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 <p>Note: Primary care providers are limited to general practitioners, family practitioners, internists and pediatricians.</p>	<p>In-network primary care provider: \$20 copayment (No deductible)</p> <p>In-network specialist provider: \$35 copayment (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay
Diagnostic and treatment services (cont.)	High Option
<p>Note: Preauthorization is required for certain specialty drugs. See Section 3, <i>How you get care</i> for information on specialty drugs administered in your physician's office or an outpatient setting.</p> <p>Note: We pay for surgery services by a physician under Section 5(b), <i>Surgical services</i>.</p> <p>Note: Telehealth consultations are covered when your provider uses a Health Insurance Portability and Accountability Act (HIPAA) compliant tool for facilitating telehealth consultations.</p> <p>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 <i>durable medical equipment</i> for coverage of diabetic supplies.</p> <p><i>Outpatient physical therapy, occupational therapy, and speech therapy</i> are covered under Section 5(a).</p> <p>Treatment for <i>Mental and Behavioral Health Disorders and Substance Use Disorder</i> is covered under Section 5(e).</p>	<p>In-network primary care provider: \$20 copayment (No deductible)</p> <p>In-network specialist provider: \$35 copayment (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Injections 	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Outpatient care in an urgent care facility because of a medical emergency <p>Note: we pay medical supplies, medical equipment, prosthetic and orthopedic devices for use at home under Section 5(a), <i>Medical services and supplies</i>.</p>	<p>In-network: \$35 copayment (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Professional services of physicians (except in an urgent care center)</p> <ul style="list-style-type: none"> • During a hospital or observation stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • In your home <p>Note: We cover contraceptive drugs under <i>Prescription Drug Benefits</i>, Section 5(f).</p>	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Professional non-emergency services provided in a walk-in clinic (except in a MinuteClinic®), including telehealth visits (see <i>Definitions</i>, Section 10)</p> <p>Note: For services related to an <i>accidental injury or medical emergency</i>, see Section 5(d)</p>	<p>In-network: \$10 copayment per visit (No deductible).</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
<p>Professional non-emergency services provided in a MinuteClinic®, including telehealth visits</p>	<p>In-network: Nothing (No deductible).</p> <p>Out-of-network: No Benefit</p>

Diagnostic and treatment services - continued on next page

Benefit Description	You Pay
Diagnostic and treatment services (cont.)	High Option
<p>If you are provided drugs (including diabetic drugs) directly by a physician, infusion care provider or durable medical equipment (DME) provider.</p>	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
Telehealth Services	High Option
<p>Telehealth consultations are available to members in the 50 United States with primary care and specialty providers through Teladoc® such as:</p> <ul style="list-style-type: none"> • Doctors of Medicine (MD) • Doctors of Osteopathic Medicine (DO) • Dermatologists • Nutritionists • Licensed Clinical Social Workers (LCSW) • Psychiatrists • Psychologists <p>See www.teladoc.com/Aetna or call 855-835-2362 (855-Teladoc) for information regarding consults.</p> <p>See Section 5(h), <i>Wellness and Other Special Features</i> for additional information.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: No benefit</p>
<p><i>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.</i></p>	<p><i>All Charges</i></p>
Lab, X-ray and other diagnostic tests	High Option
<p>Tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap test • Pathology • X-ray • Non-routine mammogram • CT/CAT Scan • MRI • Ultrasound • Electrocardiogram and EEG • Sonograms • Hearing test for non-auditory illness or disease • Medically appropriate genetic counseling and testing <p>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.</p>	<p>In-network: 15% of Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p> <p>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.</p> <p>Note: For genetic testing for prescription drugs see Section 5 (h), <i>Wellness and Other Special features</i>.</p>

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

Benefit Description	You Pay
Lab, X-ray and other diagnostic tests (cont.)	High Option
<p>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.</p>	<p>In-network: 15% of Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p> <p>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.</p> <p>Note: For genetic testing for prescription drugs see Section 5 (h), <i>Wellness and Other Special features</i>.</p>
<ul style="list-style-type: none"> • CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT, provided at a stand-alone imaging center or clinic <p>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 <i>Radiology Imaging</i> under <i>You need prior Plan approval for certain services</i>, Section 3, <i>Other services</i>.</p> <p>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.</p> <p>Note: Expenses for related professional services are covered under this benefit.</p>	<p>In-network: 5% of Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount.</p>
Lab Savings Program	High Option
<p>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, they can call Quest Diagnostics at 866-697-8378 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.</p> <p>Please Note: To find an approved collection site near you, call Quest Diagnostics at 866-697-8378 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.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: No benefit</p> <p>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.</p>
Preventive care, adult	High Option
<p>A routine physical exam – one per person each calendar year.</p> <p>Note: This includes a separate gynecological exam once per calendar year for women.</p> <p>Note: Lab tests and X-rays are covered under <i>Lab, X-ray and other diagnostic tests</i>, Section 5(a), unless coded as routine.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Preventive care, adult - continued on next page

Benefit Description	You Pay
<p>Preventive care, adult (cont.)</p> <p>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.</p> <p>The following preventive services are covered at the time interval recommended at each of the links below unless otherwise stated in this Section:</p> <ul style="list-style-type: none"> • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at www.shorturl.at/hovHM • Colorectal cancer screening, including: <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy screening - every five years - Colonoscopy screening - every ten years • Medical nutrition therapy and Intensive Behavioral Therapy, including prevention of obesity related co-morbidities, up to 26 visits combined per calendar year • Individual counseling on prevention and reducing health risks • Prostate cancer screening (PSA) - once per calendar year for members age 40 -69 • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits go to the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women. • Screening and counseling for prenatal and postpartum depression • Routine mammogram <p>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.</p> <p>To build your personalized list of preventive services go to https://health.gov/myhealthfinder.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Immunizations such as Pneumococcal, influenza, shingles, tetanus/Tdap, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: Nothing up to the Plan allowance then any difference between our allowance and the billed amount (No deductible)</p>

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	High Option
<p>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.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: Nothing up to the Plan allowance then any difference between our allowance and the billed amount (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> 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. 	<p><i>All charges</i></p>
Preventive care, children	High Option
<p>For covered dependent children under age 22:</p> <ul style="list-style-type: none"> Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org. Immunizations such as DTaP/Tdap, Measles, Mumps, Polio and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at www.cdc.gov/vaccines/schedules/index.html Body mass index (BMI) testing for children under age 22 Medical nutrition therapy and Intensive Behavioral Therapy, including prevention of obesity related co-morbidities, unlimited Hearing screening exam testing, diagnosis and treatment (including hearing aids for hearing loss) Retinal screening exam performed by an ophthalmologist for infants with low birth weight, less than 1 year of age and with unstable clinical course <p>You may also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations.</p> <p>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.</p> <p>To build your personalized list of preventive services go to https://health.gov/myhealthfinder.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: Nothing up to Plan allowance then the difference between our allowance and the billed amount (No deductible)</p>
<p><i>Not covered:</i></p>	<p><i>All charges</i></p>

Preventive care, children - continued on next page

Benefit Description	You Pay
Preventive care, children (cont.)	High Option
<ul style="list-style-type: none"> 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	High Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care (including laboratory tests) Delivery Anesthesia Postpartum care Sonograms Screening for gestational diabetes Screening and counseling for prenatal and postpartum depression <p>Note: For facility care related to maternity, see Section 5(c), <i>Services Provided by a Hospital or Other Facility, and Ambulance Services</i>.</p> <p>Note: For services related to an <i>accidental injury or medical emergency</i>, see Section 5(d).</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>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.</p>
<p>Physical and emotional support provided during pregnancy, childbirth and postpartum by a certified doula</p>	<p>In-network and out-of-network: Nothing up to the Plan maximum of \$1,200 per person, per calendar year; then all charges (No deductible)</p>
<p>Medically appropriate genetic counseling and testing is covered under <i>Maternity care</i> for maternity related genetic tests.</p> <p>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.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>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.</p>
<ul style="list-style-type: none"> Breastfeeding support, supplies and counseling for each birth Breastfeeding equipment rental or purchase <p>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.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p>

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	High Option
<p>Note: Breastfeeding supplies such as maternity bras, nursing pads or additional bottles are not covered.</p> <p>Note: When breastfeeding equipment and supplies are purchased at a CVS Pharmacy, you pay nothing (No deductible).</p> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your vaginal delivery; see Section 3. <i>How You Get Care for other circumstances</i>, 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 <i>accidental injury or medical emergency</i>, see Section 5(d). • <i>Hospital services</i> are covered under Section 5(c) and <i>Surgical benefits</i> Section 5(b). <p>Note: When a newborn requires definitive treatment during or after the mother’s hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.</p> <p>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 they 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.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay
Family Planning	
<p>Contraceptive counseling on an annual basis</p>	<p>In-network: Nothing Out-of-network: Nothing</p>
<p>A range of voluntary family planning services, including patient education and counseling, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Section 5(b), <i>Surgical procedures</i>) • Injection of contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptive drugs, diaphragms, cervical caps, vaginal rings and contraceptive hormone patches, see Section 5(f), <i>Prescription drug benefits</i>.</p> <p>Note: Surgically implanted, fitting, insertion or removal of contraceptive devices is covered under <i>Surgical Services</i>, Section 5(b).</p> <p>Note: For genetic counseling and testing please refer to Section 5(a), <i>Lab, X-ray and other diagnostic tests</i>.</p>	<p>In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Cost of donor sperm or egg</i> 	<p><i>All charges</i></p>
Infertility services	
<p>Infertility is defined when a person is unable to conceive or produce conception after 1 year of egg sperm contact when the female (or individual with female reproductive organs) attempting conception is under 35 years of age, or after 6 months of egg-sperm contact when the individual attempting conception is 35 years or older. Egg-sperm contact can be achieved by sexual intercourse or through attempted egg-sperm insemination (intrauterine, intracervical, or intravaginal). This definition applies to all individuals regardless of sexual orientation or the presence/availability of a partner. Infertility may also be established by the demonstration of a disease of the reproductive tract such that regular egg-sperm contact would be ineffective.</p> <p>The Plan covers three different levels of infertility treatment to include Basic Infertility, Comprehensive Infertility, and Advanced Reproductive Technology (ART).</p> <p>Note: Prior approval is required for Comprehensive Infertility and ART. Call us at 800-575-5999 prior to scheduling. See Section 3, <i>Other services</i>.</p>	<p>High Option</p>

Infertility services - continued on next page

Benefit Description	You Pay
<p>Infertility services (cont.)</p>	<p>High Option</p>
<p>Note: For services listed under Comprehensive Infertility and ART, you must use a provider who participates in our Institutes of Excellence™ (IOE) Infertility Providers. For additional information regarding the IOE Infertility Providers, please call 800-575-5999 or visit www.aetnainfertilitycare.com.</p> <p>Note: The Plan offers a fertility advocate to support you through your infertility journey. To speak directly with a fertility advocate call 833-415-1709.</p> <p>Note: Drugs for the treatment of infertility are covered under Section 5(f), <i>Prescription Drug Benefits</i>.</p>	
<p>Basic Infertility</p> <ul style="list-style-type: none"> • Initial diagnostic tests and procedures done only to identify the cause of infertility, • Medical or surgical procedures done to create or enhance fertility • Fertility preservation procedures (retrieval of and freezing of eggs or sperm) for members facing possibility of infertility caused by chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or ovary or testicle removal for treatment of disease 	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Comprehensive Infertility</p> <ul style="list-style-type: none"> • Artificial insemination (AI) and monitoring of ovulation to include: <ul style="list-style-type: none"> - Intracervical insemination (ICI) - Intrauterine insemination (IUI) - Intravaginal insemination (IVI) • Ovulation induction cycle(s) while an injectable medication to stimulate the ovaries • Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services <p>Note: The Plan defines a cycle as:</p> <ul style="list-style-type: none"> • An attempt at ovulation induction while on injectable medication to stimulate the ovaries with or without artificial insemination; or • An artificial insemination cycle with or without injectable medication to stimulate the ovaries <p>You are eligible for Comprehensive Infertility if:</p> <ul style="list-style-type: none"> • You or your partner have been diagnosed with infertility (see elsewhere in this section for definition of infertility). • You have met the requirement for the number of months trying to conceive through egg and sperm contact. • You or your partner have not gone through voluntary sterilization with or without reversal 	<p>Institutes of Excellence™ (IOE) Infertility Providers: 15% of the Plan allowance</p> <p>Out-of-network: No benefit</p>

Benefit Description	You Pay
<p>Infertility services (cont.)</p> <ul style="list-style-type: none"> Your unmedicated day three (3) Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna’s Clinical Policy Bulletin (CPB) for Infertility (visit www.RCBPhealth.com to access the CPB – Infertility). 	<p>High Option</p> <p>Institutes of Excellence™ (IOE) Infertility Providers: 15% of the Plan allowance</p> <p>Out-of-network: No benefit</p>
<p>Advanced Reproductive Technology (ART)</p> <ul style="list-style-type: none"> In vitro fertilization (IVF) Embryo transfer and gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT) Intracytoplasmic sperm injection (ICSI) Iatrogenic fertility preservation procedures (retrieval of and freezing of eggs or sperm) caused by chemotherapy, pelvic radiotherapy, ovary or testicle removal and other gonadotoxic therapies for the treatment of disease. <p>Note: We limit coverage for ART to two (2) complete cycles per calendar year. The Plan defines a cycle as:</p> <ul style="list-style-type: none"> One complete fresh IVF cycle with transfer (egg retrieval, fertilization, and transfer of embryo) One complete GIFT cycle One complete ZIFT cycle <p>You are eligible for ART if:</p> <ul style="list-style-type: none"> You have failed to conceive after a trial of ovarian stimulation: <ul style="list-style-type: none"> For women 37 years of age or younger, three cycles of ovarian stimulation (with or without intrauterine insemination); or For women 38 years of age or older, no trial of ovarian stimulation is required Natural or artificial insemination would not be expected to be effective, and ART would be expected to be the only effective treatment. 	<p>Institutes of Excellence™ (IOE) Infertility Providers: Nothing up to the Plan maximum for two complete cycles per person, per calendar year; then all charges (No deductible)</p> <p>Out-of-network: No benefit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Infertility services after voluntary sterilization</i> <i>Cost of donor sperm</i> <i>Cost of donor egg</i> <i>Elective fertility preservation, such as egg freezing sought due to natural aging</i> <i>Storage costs</i> <i>Costs for obtaining sperm from a person not covered under this Plan</i> <i>Infertility treatment when a successful pregnancy could have been obtained through less costly treatment</i> 	<p><i>All charges</i></p>

Infertility services - continued on next page

Benefit Description	You Pay
Infertility services (cont.)	High Option
<ul style="list-style-type: none"> • <i>Infertility treatment when infertility is due to a natural physiologic process such as age-related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two (2) or three (3) of your menstrual cycle or other abnormal testing results as outlined in Aetna's Infertility Clinical Policy</i> • <i>Injectable infertility medication including but not limited to menotropins, hCG, and GnRH agonists, except as described in Section 5(f). Prescription Drug Benefit</i> • <i>Any Comprehensive Infertility Services or ART services not prior approved by the Plan</i> • <i>Coverage for services received by a spouse or partner who is not a covered member under the Plan</i> 	<p><i>All charges</i></p>
Allergy care	High Option
<ul style="list-style-type: none"> • Testing, including the RAST test, and treatment, including materials (such as allergy serum) <p>Note: If your physician uses the Quest Diagnostics or LabCorp to test your specimen, you will pay nothing for the lab test.</p> <p>Note: The allergy services are included in the office visit copayment if performed during an office visit with a network provider.</p>	<p>In-network: Services in a physician's office --\$20 copayment (No deductible)</p> <p>Services outside the physician's office—15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Allergy injections 	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Food tests</i> • <i>End point titration techniques</i> • <i>Sublingual allergy desensitization</i> • <i>Hair analysis</i> 	<p><i>All charges</i></p>
Treatment therapies	High Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 46-49.</p> <ul style="list-style-type: none"> • Intravenous (IV)/infusion therapy – home IV and antibiotic therapy • Human growth hormone therapy (HGHT) • Respiratory and inhalation therapies • Cardiac rehabilitation therapy 	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Note: The Plan pays for services, supplies, and tests rendered for the direct treatment of cancer under <i>Wellness and Other Special features</i>, Section 5(h).</p> <p>Note: The Plan pays for services, supplies, and testing for kidney (renal) dialysis under <i>Wellness and Other Special features</i>, Section 5(h).</p>

Treatment therapies - continued on next page

Benefit Description	You Pay
<p>Treatment therapies (cont.)</p> <p>Note: We cover only Phase 1 and 2 for cardiac rehabilitation therapy.</p> <ul style="list-style-type: none"> Biofeedback only when treating incontinence, migraines, pain management, temporomandibular joint (TMJ) and irritable bowel syndrome (IBS). <p>Note: Applied Behavioral Analysis (including the assessment) is covered under Section 5(e), <i>Mental Health and Substance Use Disorder Benefits</i> and requires prior approval. See Section 3, under <i>How you get care</i>.</p> <p>Note: Preauthorization is required for certain specialty drugs. See Section 3, <i>How you get care</i> for information on specialty drugs administered in your physician's office or an outpatient setting.</p>	<p style="text-align: center;">High Option</p> <p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p> <p>Note: The Plan pays for services, supplies, and tests rendered for the direct treatment of cancer under <i>Wellness and Other Special features</i>, Section 5(h).</p> <p>Note: The Plan pays for services, supplies, and testing for kidney (renal) dialysis under <i>Wellness and Other Special features</i>, Section 5(h).</p>

Treatment therapies - continued on next page

Benefit Description	You Pay
Treatment therapies (cont.)	High Option
<p>Services and supplies related to Gene-Based Cellular and other Innovative Therapies (GCIT™) include:</p> <ul style="list-style-type: none"> • Cellular immunotherapies • Genetically modified oncolytic viral therapy • Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions other than transplants • Human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using: Luxturna® (<i>Voretigene neparvovec</i>), Zolgensma® (<i>Onasemnogene abeparvovec-xioi</i>), Spinraza® (<i>Nusinersen</i>) • Products derived from gene editing technologies, including CRISPR-Cas9 • Oligonucleotide-based therapies including: <ul style="list-style-type: none"> - Antisense (Example: Spinraza®) - siRNA <p>To receive the in-network level of benefits, you must use a provider who participates in our GCIT Designated Network.</p> <p>Note: Prior approval is required. Call us at 800-638-8432 prior to scheduling. See Section 3, <i>Other services</i>.</p> <p>Note: See Section 5(c), <i>Outpatient hospital or ambulatory surgical center</i> for services provided by a hospital.</p> <p>Note: The Plan has special arrangements with facilities to provide services and supplies related to GCIT and may provide travel assistance, see Section 5(h), <i>Wellness and Other Special Features, GCIT Designated Network</i>. For additional information regarding the GCIT Designated Network, please call 800-638-8432.</p>	<p>GCIT Designated Network: 15% of the Plan allowance</p> <p>Out-of-network: No benefit</p>
Physical and occupational and speech therapies	High Option
<p>For physical therapy, speech therapy and occupational therapy:</p> <ul style="list-style-type: none"> • 90 total combined visits per calendar year <p>Note: We provide physical, occupational and speech therapy for those diagnosed with Autism.</p> <p>Note: For physical, occupational and speech therapy for autism and developmental delays, see Section 5(e), <i>Physical, occupational and speech therapies</i>.</p> <p>Note: <i>Inpatient physical, occupational and speech therapies</i> are covered under Section 5(c).</p>	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> 	<p><i>All charges</i></p>

Physical and occupational and speech therapies - continued on next page

Benefit Description	You Pay
Physical and occupational and speech therapies (cont.)	High Option
<ul style="list-style-type: none"> • <i>Exercise programs</i> 	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • Routine hearing exam, including evaluation and diagnostic hearing tests performed by an M.D., D.O. or audiologist <p>Note: For routine hearing screening performed during a child’s preventive care visit, see Section 5(a), <i>Preventive care, children</i>.</p> <p>Note: For benefits for adult hearing devices, see Section 5 (a), <i>Orthopedic and prosthetic devices</i>.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: Nothing (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hearing aids and related expenses, except as noted above</i> 	<i>All charges</i>
Vision services (testing, treatment, and supplies)	High Option
<ul style="list-style-type: none"> • 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 <p>Note: See <i>Orthopedic and prosthetic devices</i> in this section for intraocular lens coverage.</p> <p>Note: Diabetic retinal eye exams are covered under Section 5 (a), <i>Diagnostic and treatment services</i>.</p>	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Routine eye exam, including refractions</p> <p>Note: The itemized bill must show that you had a routine eye exam to qualify for this benefit.</p>	<p>In-network: Nothing up to \$45, then all charges (No deductible)</p> <p>Out-of-network: Nothing up to \$45, then all charges (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses, except as shown above</i> • <i>Deluxe lens features for eyeglasses or contact lenses such as special coatings, polarization and UV treatment</i> • <i>Eye exercises and orthoptics</i> • <i>Refractive eye surgery and related expenses</i> • <i>All refractive corneal or intraocular surgeries for vision correction without an underlying medical condition</i> 	<i>All charges</i>

Benefit Description	You Pay
Foot care	High Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	<p>In-network: 15% of Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Treatment or removal of corns and calluses, or trimming of toenails, except as stated above</i> • <i>Orthopedic shoes and other devices to support the feet, except as shown in Section 5(a), Orthopedic and prosthetic devices</i> 	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	High Option
<ul style="list-style-type: none"> • 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 intraocular lens (IOLs), cochlear implants, bone anchored hearing aids (BAHA), artificial joints, pacemakers and surgically implanted breast implant following mastectomy <p>Note: Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom are covered.</p> <p>Note: See Section 5(b) for <i>coverage of the surgery</i> to insert the device and Section 5(c) for <i>services provided by a hospital</i>.</p>	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Up to \$500 for wigs needed as a result of chemotherapy or radiation treatment for cancer <p>Note: This benefit is available once per calendar year.</p>	<p>In-network: Nothing up to \$500, then all charges (No deductible)</p> <p>Out-of-network: Nothing up to \$500, then all charges (No deductible)</p>
<p>Hearing aids for adults</p> <ul style="list-style-type: none"> • Adult hearing aids and related services. <p>Note: This benefit is available once every three years.</p>	<p>In-network: Nothing up to \$3,000 per adult, then all charges (No deductible)</p> <p>Out-of-network: Nothing up to \$3,000 per adult, then all charges (No deductible)</p>
<p>Foot orthotics</p> <ul style="list-style-type: none"> • Prescribed by a physician • Custom fitted, including necessary repair and adjustment • Impression casting • Corrective shoes to treat malformation and weakness of the foot 	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Corsets, trusses, and other supportive devices, unless we determine their medical necessity</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay
<p>Durable medical equipment (DME)</p> <p>Durable medical equipment (DME) is equipment and supplies that:</p> <ul style="list-style-type: none"> • 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 <p>We cover rental, up to the purchase price, or purchase (at our option), including necessary repair and adjustment, of durable medical equipment, such as:</p> <ul style="list-style-type: none"> • 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 healthcare 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: <ul style="list-style-type: none"> - 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 <p>Note: Coverage is limited to the seat lift mechanism only, even if the mechanism is part of a chair.</p> <p>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.</p>	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	High Option
<p>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.</p> <p>Note: We will cover charges for service contracts for medically necessary durable medical equipment that is purchased or rented.</p>	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Augmentative and alternative communications (AAC) devices such as:</p> <ul style="list-style-type: none"> • 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 	<p>In-network: Nothing up to a maximum of \$1,000 per device per calendar year (No deductible)</p> <p>Out-of-network: Nothing up to a maximum of \$1,000 per device per calendar year (No deductible)</p> <p>Note: Limited to one device per person per calendar year</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Sun or heat lamps, whirlpool bath, heating pads, air purifiers, humidifiers, air conditioners and exercise devices</i> • <i>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</i> • <i>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</i> 	<p><i>All charges</i></p>
Home health services	High Option
<p>We pay for up to 90 visits per person per calendar year when:</p> <ul style="list-style-type: none"> • 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. <p>Note: Services of a licensed social worker are included in the 90 visit calendar year maximum.</p>	<p>In-network: 15% of the Plan allowance (No deductible). You pay all charges after 90 visits per calendar year.</p> <p>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.</p>

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	High Option
<p>Note: For physical, occupational and/or speech therapy services performed during a home health visit see Section 5 (a), <i>Physical, occupational and speech therapy</i>.</p>	<p>In-network: 15% of the Plan allowance (No deductible). You pay all charges after 90 visits per calendar year.</p> <p>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.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient’s family;</i> • <i>Services consisting of only hygiene, feeding, exercising, moving the patient, homemaking, companionship, or giving oral medication;</i> • <i>Custodial care as defined in Section 10</i> 	<p><i>All charges</i></p>
Chiropractic	High Option
<ul style="list-style-type: none"> • Manipulation of the spine and extremities 	<p>In-network: \$20 copayment per visit (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
Alternative treatments	High Option
<p>Acupuncture for:</p> <ul style="list-style-type: none"> • Anesthesia • Pain relief • Therapeutic purposes <p>Note: Please see the definition of <i>acupuncture</i> in Section 10.</p>	<p>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.</p> <p>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.</p>
<p>Massage therapy only when performed by a covered provider (see Section 3) limited to 30 visits per person, per calendar year</p> <p>Note: Massage therapy is limited to one visit per day.</p> <p>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, <i>Filing a claim for covered services</i>.</p>	<p>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.</p> <p>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.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Chelation therapy, except for arsenic, gold, lead or mercury poisoning and the use of desferoxamine for iron poisoning</i> • <i>Rolfing</i> • <i>Cupping</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay
Educational classes and programs	High Option
<p>Tobacco Cessation Program</p> <ul style="list-style-type: none"> 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. <p>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), <i>Prescription drug benefits</i> for more details.</p> <p>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).</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: Nothing (No deductible)</p>
<p>Diabetic education</p> <ul style="list-style-type: none"> One diabetic education and training program per person each calendar year. 	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p>
<p>Telephonic Health Coach Program</p> <p>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:</p> <ul style="list-style-type: none"> Tobacco cessation Weight management Exercise Nutrition Stress management Pain management and opioid support High blood pressure High cholesterol <p>See the Plan’s benefit, Telephonic Health Coach Program, in Section 5(h), <i>Wellness and Other Special features</i>.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: No benefit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Body composition analysis</i> <i>Nutritional supplements or food, except those covered under Section 5(a), Durable medical equipment</i> <i>Non-prescription drugs or supplies</i> 	<p><i>All charges</i></p>

Educational classes and programs - continued on next page

Benefit Description	You Pay
Educational classes and programs (cont.)	High Option
<ul style="list-style-type: none"> • <i>Exercise or weight loss programs and exercise equipment</i> • <i>Services that are not medically necessary</i> 	<i>All charges</i>

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 healthcare professional for your surgical care. See Section 5(c) for charges associated with a 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 AFFIRMING 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.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of \$75 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

Benefit Description	You Pay After the calendar year deductible...
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible...
High Option	
<ul style="list-style-type: none"> • Treatment of burns 	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Gender affirming surgery is considered medically necessary for the following services when all criteria has been met:</p> <ul style="list-style-type: none"> - breast removal - breast augmentation (implants/lipofilling) - gonadectomy (hysterectomy and oophorectomy or orchiectomy) - genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, placement of a testicular prosthesis and erectile prosthesis, penectomy, vaginoplasty, labiaplasty, and clitoroplasty) - facial and body contouring services <p>Note: Prior approval is required. Call us at 800-638-8432 or visit www.RCBPHealth.com/gender-affirming-care for more information.</p> <p>Note: Hormone therapy is covered under Section 5(f), <i>Prescription drug benefits</i>. Prior authorization may be required.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Surgical treatment of severe 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, nonalcoholic steatohepatitis (NASH) or hyperlipidemia, and; (2) has been under at least one physician supervised weight loss program for 12 or more sessions and occurred within 2 years prior to surgery. The program should be multi-disciplinary by combining diet and nutritional counseling with an exercise program and a behavior modification program.</p> <p>Note: Prior approval is required. Call us at 800-638-8432 for more information. See Section 3, <i>Other services</i>.</p> <p>Insertion of internal prosthetic devices. See Section 5 (a), <i>Orthopedic and prosthetic devices</i> for device coverage information</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<ul style="list-style-type: none"> • Voluntary male sterilization (e.g., vasectomy) • Voluntary female sterilization (e.g., tubal ligation) • Surgically implanted contraceptives • Intrauterine devices (IUDs) 	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Surgical procedures (cont.)	High Option
<p>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.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>When multiple or bilateral surgical procedures are performed during the same operative session by the same surgeon, our benefits are:</p> <ul style="list-style-type: none"> • 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) <p>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.</p>	<p>In-network: 15% of the Plan allowance for the primary procedure (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance for the individual procedure and any difference between our allowance and the billed amount</p>
<p>Co-surgeons</p> <p>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.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Assistant Surgeons</p> <p>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).</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>All refractive eye surgeries and similar services</i> 	<p><i>All charges</i></p>

Surgical procedures - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Surgical procedures (cont.)	High Option
<ul style="list-style-type: none"> • <i>Dental appliances, study models, splints, and other devices or service related to the treatment of TMJ dysfunction</i> • <i>Treatment or removal of corns and calluses, or trimming of toenails</i> • <i>Mutually exclusive procedures-- surgical procedures that are not generally performed on one patient on the same day</i> • <i>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.</i> <p><i>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 affirming surgery as noted on the previous page.</i></p> <ul style="list-style-type: none"> • <i>Gender affirming surgery, other than the surgeries listed as covered</i> • <i>Reversal of gender affirming surgery</i> 	<p><i>All charges</i></p>
Reconstructive surgery	High Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - 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), <i>Prosthetic devices</i> for coverage) 	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Reconstructive surgery - continued on next page

Benefit Description	You Pay After the calendar year deductible...
High Option	
<p>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.</p>	<p>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</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> <p><i>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 affirming surgery as noted on the previous page</i></p>	<p><i>All charges</i></p>
High Option	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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 • Oral surgical biopsy • Surgical correction of temporomandibular joint (TMJ) dysfunction • Frenectomy and frenotomy not as a result of orthodontic care 	<p>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</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants and related services</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay After the calendar year deductible...
<p>Organ/tissue transplants</p> <p>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, <i>Other services</i> for prior approval procedures.</p> <p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants <ul style="list-style-type: none"> - 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 	<p style="text-align: center;">High Option</p> <p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>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, <i>Other services</i> for prior approval procedures.</p> <ul style="list-style-type: none"> • Autologous tandem transplants for: <ul style="list-style-type: none"> - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer) 	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Blood or marrow stem cell transplants</p> <p>The Plan extends coverage for the diagnoses as indicated below:</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - 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 	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Leukocyte adhesion deficiencies - Kostmann’s syndrome - Marrow failure and related disorders (i.e., Fanconi’s, Paroxysmal nocturnal hemoglobinuria, Pure Red Cell Aplasia) - Mucopolysaccharidosis (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: <ul style="list-style-type: none"> - 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 - Ependyoblastoma - Medullablastoma - Ewing’s sarcoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors - Waldenstorm’s macroglobulinemia 	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<p>Mini-transplants (non-myeloblastic 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, <i>Other services for prior approval procedures</i>.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin’s lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin’s lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic 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: <ul style="list-style-type: none"> - 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 	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>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.</p> <p>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.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for: <ul style="list-style-type: none"> - 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: <ul style="list-style-type: none"> - Advanced Hodgkin’s lymphoma - Advanced Ewing sarcoma - Advanced Childhood kidney cancers - Advanced non-Hodgkin’s lymphoma - Aggressive non-Hodgkin’s lymphomas 	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

Organ/tissue transplants - continued on next page

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> - Breast cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial ovarian cancer - Mantle Cell (Non-Hodgkin lymphoma) - Small cell lung cancer • Autologous transplants for the following autoimmune diseases: <ul style="list-style-type: none"> - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive) <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p> <p>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.</p> <p>Note: We cover donor screening and search expenses for up to four (4) candidate donors per transplant in addition to testing family members.</p> <p>Note: Aetna has special arrangements with transplant facilities to provide services for tissue and organ transplants (see Section 5(h), <i>Wellness and Other Special features, Institutes of Excellence</i>). 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.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except as shown above</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay After the calendar year deductible...
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<i>All charges</i>
Anesthesia	High Option
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Physician's office <p>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.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>

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 healthcare 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.**
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of \$75 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

Benefit Description	You Pay
Note: The calendar year deductible applies ONLY when we say below: “(calendar year deductible applies)”.	
Inpatient hospital	High Option
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets <p>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.</p> <p>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.</p> <p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • 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 <p>Note: We base payment on whether the facility or a healthcare 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.</p>	<p>In-network: \$200 copayment for each hospital admission (copayment waived for a maternity stay)</p> <p>Out-of-network: \$400 copayment for each hospital admission and 30% of the Plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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.</i> • <i>Hospital charges for non-covered surgery</i> 	<p><i>All charges</i></p>

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	High Option
<ul style="list-style-type: none"> • 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	High Option
<ul style="list-style-type: none"> • 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 <p>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 healthcare professionals in connection with the dental treatment.</p> <p>We base payment on whether the facility or a healthcare professional bills for the services or supplies. For example, when the physician bills for surgery, we pay Surgery benefits.</p>	<p>In-network: 15% of the Plan allowance (calendar year deductible applies) (cost-share is waived for maternity services)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (calendar year deductible applies)</p>
<p>Outpatient observation care 24 hours or more performed and billed by a hospital or freestanding ambulatory facility.</p> <p>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 <i>services billed by professional providers</i> during an observation stay.</p>	<p>In-network: \$200 copayment for each hospital admission (copayment waived for a maternity stay)</p> <p>Out-of-network: \$400 copayment for each hospital admission and 30% of the covered charges</p>

Outpatient hospital or ambulatory surgical center - continued on next page

Benefit Description	You Pay
<p>Outpatient hospital or ambulatory surgical center (cont.)</p> <p>Services and supplies related to Gene-Based Cellular and other Innovative Therapies (GCIT™) include:</p> <ul style="list-style-type: none"> • Cellular immunotherapies • Genetically modified oncolytic viral therapy • Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions other than transplants • Human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using: Luxturna® (<i>Voretigene neparvovec</i>), Zolgensma® (<i>Onasemnogene abeparvovec-xioi</i>), Spinraza® (<i>Nusinersen</i>) • Products derived from gene editing technologies, including CRISPR-Cas9 • Oligonucleotide-based therapies including: <ul style="list-style-type: none"> - Antisense (Example: Spinraza®) - siRNA <p>To receive the in-network level of benefits, you must use a provider who participates in our GCIT Designated Network.</p> <p>Note: Prior approval is required. Call us at 800-638-8432 prior to scheduling. See Section 3, <i>Other services</i>.</p> <p>Note: See Section 5(a), <i>Treatment therapies</i> for services provided by a physician.</p> <p>Note: The Plan has special arrangements with facilities to provide services and supplies related to GCIT and may provide travel assistance, see Section 5(h), <i>Wellness and Other Special Features, GCIT Designated Network</i>. For additional information regarding the GCIT Designated Network, please call 800-638-8432.</p>	<p>GCIT Designated Network: 15% of the Plan allowance (calendar year deductible applies)</p> <p>Out-of-network: No benefit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Outpatient hospital services/supplies for surgery we do not cover except as noted above.</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay
Extended care benefits/Skilled nursing care facility benefits	High Option
<p>We cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 60 days per calendar year when:</p> <ul style="list-style-type: none"> • The stay is medically necessary • The stay is supervised by a physician <p>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.</p> <p>Note: Skilled nursing facility admissions require precertification; failure to do so will result in a minimum \$500 penalty.</p>	<p>In-network: \$200 copayment for each admission and all charges in excess of the 60-day maximum</p> <p>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</p>
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> 	<p><i>All charges</i></p>
Hospice care	High Option
<p>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.</p> <p>Note: This benefit does not apply to services covered under any other benefit of the Plan.</p> <p>Note: See Section 5(h), <i>Wellness and Other Special Features, Care Management Program</i> for more information on advance care planning.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Private duty nursing</i> • <i>Custodial care</i> • <i>Homemaker services</i> • <i>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.</i> 	<p><i>All charges</i></p>

Benefit Description	You Pay
Ambulance	High Option
<ul style="list-style-type: none"> Professional ambulance service to the nearest facility equipped to handle the patient's condition, including air ambulance when medically necessary. <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p> <p>Note: See Section 5(d) for <i>emergency ambulance service</i>.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Ambulance transportation for your own or your family's convenience</i> <i>Transportation to other than a hospital, skilled nursing facility, dialysis, hospice or urgent care medical facility</i> <i>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</i> 	<p><i>All charges</i></p>

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 an in-network facility, keep in mind that the healthcare 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.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of \$75 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

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...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</p>	
Accidental injury	High Option
<p>If you or a family member is accidentally injured, the Plan will pay up to the Plan allowance for:</p> <ul style="list-style-type: none"> • 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 	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: The difference between the Plan allowance and the billed amount (No deductible)</p>

Accidental injury - continued on next page

Benefit Description	You pay After the calendar year deductible...
High Option	
<p>Accidental injury (cont.)</p> <ul style="list-style-type: none"> 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 <p>Note: Regular Plan benefits apply after the initial ER, urgent care, physician, or other healthcare professional office visit.</p> <p>Note: We pay for services performed outside the ER or urgent care facility under the appropriate Plan benefit.</p> <p>Note: We pay hospital benefits as specified in Section 5(c), <i>Services provided by a hospital or other facility</i> if you are admitted to the hospital.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: The difference between the Plan allowance and the billed amount (No deductible)</p>
High Option	
<p>Medical emergency</p> <p>Plan benefits are paid for care you receive because of a medical emergency (non-accident) like a heart attack or stroke, including anesthesia.</p> <p>Note: Regular Plan benefits apply after initial ER, physician's, or other healthcare professional's office visit.</p> <p>Note: We pay emergency room fees billed by the hospital as Inpatient hospital benefits as specified in Section 5(c), <i>Inpatient hospital</i> if you are admitted as an inpatient through the emergency room.</p>	<p>In-network: Services in a primary care provider's office--\$20 copayment (No deductible)</p> <p>In-network: Services in a specialist provider's office--\$35 copayment (No deductible)</p> <p>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p> <p>In-network: Services outside the primary care provider's or specialist provider's office— \$200 copayment (No deductible)</p> <p>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)</p>
<p>Services you receive for your medical emergency in an urgent care center.</p> <p>Note: We pay medical supplies, medical equipment, prosthetic and orthopedic devices for use at home under Section 5(a), <i>Medical services and supplies</i>.</p>	<p>In-network: \$35 copayment per occurrence (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
High Option	
<p>Ambulance</p> <ul style="list-style-type: none"> Professional ambulance service to the nearest facility equipped to handle the patient's condition, including air ambulance when medically necessary. <p>Note: We also cover medically necessary emergency care provided at the scene when transport services are not required.</p> <p>Note: See 5(c) for <i>non-emergency service</i>.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p>

Benefit Description	You pay After the calendar year deductible...
Ambulance (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Ambulance transport for your own or your family's convenience</i> • <i>Transportation to other than a hospital, skilled nursing facility, dialysis, hospice or urgent care medical facility</i> 	<p><i>All charges</i></p>

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 see 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.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of \$75 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

Benefit Description	You Pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say “(No deductible)” when it does not apply.</p>	
Professional services	High Option
<p>We cover professional services, including telehealth 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.</p>	<p>Your cost-sharing responsibilities are no greater than for other illnesses or conditions.</p>
<p>Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:</p> <ul style="list-style-type: none"> • Psychiatric office visits to behavioral health practitioner • Substance Use Disorder (SUD), including detoxification, treatment and counseling • Behavioral therapy • Telehealth consultations <p>Note: Telehealth consultations are covered when your provider uses a Health Insurance Portability and Accountability Act (HIPAA) compliant tool for facilitating telehealth consultations.</p>	<p>In-network: \$20 copayment (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Applied Behavioral Analysis (ABA)</p> <p>The Plan covers medically necessary applied behavioral analysis therapy including the assessment only when provided by behavioral health providers. These providers include:</p> <ul style="list-style-type: none"> • 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. <p>NOTE: Assessment and treatment for ABA requires prior approval. See Section 3, <i>How you get care</i> for information on how to precertify and obtain prior approval for your care.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Skilled behavioral health services provided in the home, but only when all of the following criteria are met:</p> <ul style="list-style-type: none"> • 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 healthcare is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications 	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Telehealth consultations are available to members in the 50 United States through Teladoc® such as:</p> <ul style="list-style-type: none"> • Doctors of Medicine (MD) • Doctors of Osteopathic Medicine (DO) 	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: No benefit</p>

Benefit Description	You Pay After the calendar year deductible...
High Option	
<p>Professional services (cont.)</p> <ul style="list-style-type: none"> • Licensed Clinical Social Workers (LCSW) • Psychiatrists • Psychologists <p>See www.teladoc.com/Actna or call 855-835-2362 (855-Teladoc) for information regarding consults.</p> <p>See Section 5(h), <i>Wellness and Other Special Features</i> for additional information.</p>	<p>In-network: Nothing (No deductible)</p> <p>Out-of-network: No benefit</p>
High Option	
<p>Diagnostics</p> <ul style="list-style-type: none"> • 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 	<p>In-network: 15% of the Plan allowance</p> <p>Out-of-network: 30% of the Plan allowance any difference between our allowance and the billed amount</p>
High Option	
<p>Physical, occupational and speech therapies</p> <p>Outpatient physical, occupational, and speech therapy visits for the diagnosis of autism and developmental delays.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
High Option	
<p>Inpatient hospital or other covered facility</p> <p>Inpatient services provided and billed by a hospital or other covered facility, including an overnight residential treatment facility (RTC)</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>In-network: \$200 copayment for each hospital admission (No deductible)</p> <p>Out-of-network: 30% of the covered charges (No deductible)</p>

Benefit Description	You Pay After the calendar year deductible...
High Option	
<p>Outpatient hospital or other outpatient services</p> <p>Outpatient services provided and billed by a hospital or other covered facility</p> <p>All other outpatient mental health treatment, including:</p> <ul style="list-style-type: none"> • 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 less than 24 hours <p>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.</p> <p>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.</p>	<p>In-network: 15% of the Plan allowance (No deductible)</p> <p>Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount</p>
<p>Outpatient observation care 24 hours or more performed and billed by a hospital or freestanding ambulatory facility</p> <p>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 <i>services billed by professional providers</i> during an observation stay.</p>	<p>In-network: \$200 copayment for each hospital admission (No deductible)</p> <p>Out-of-network: 30% of the covered charges (No deductible)</p>
High Option	
<p>Not covered</p> <ul style="list-style-type: none"> • <i>Services we have not approved</i> • <i>All charges (including room and board) for chemical aversion therapy, conditioned reflex treatments, narcotherapy, and similar aversion treatments</i> • <i>Counseling or therapy for educational, sexual paraphilias or learning disorders</i> • <i>Community based programs such as self-help groups or 12-step programs</i> 	<p><i>All charges</i></p>

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 this section.
- 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.
- Your prescribers must 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.
Note: Deductible does not apply to prescriptions if you are enrolled in our SilverScript Employer Prescription Drug Plan (PDP) for Rural Carrier Benefit Plan, see Section 9, *Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)*.
- 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.
- If you are covered by Medicare and Medicare Part A or B or Parts A and B is primary and you are not enrolled in our Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan members, we will automatically enroll you in our SilverScript Employer Prescription Drug Plan (PDP) for Rural Carrier Benefit Plan. This Medicare Part D plan enhances your FEHB coverage by offering lower cost sharing on covered drugs. You can find more details about this plan and the opt out process in Section 9, *Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)*. The PDP is subject to Medicare rules.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of \$75 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

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.rcbphhealth.com. 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 Caremark mail service pharmacy:** You may fill your long-term prescription through the CVS Caremark mail service pharmacy. You will receive order forms and information on how to use the mail service prescription program from CVS Caremark . To order your prescription by mail: 1) complete the CVS Caremark order form; 2) enclose your prescription(s) and copayment(s); 3) mail your order to CVS Caremark, P O Box 659572, San Antonio, TX 78256-9572; and 4) allow approximately two weeks for delivery. You will receive order forms for refills and future prescription orders each time you use the mail service program. You can also order refills from the mail service program by phone toll-free at 800-292-4182 or on the Internet at www.Caremark.com.

We use a formulary. A formulary is a list of generic and preferred drugs (see below) that are available through this plan. It places all U.S. Food and Drug Administration (FDA) approved drugs into categories based on their clinical effectiveness, safety and cost. The formulary is designed to control costs for you and the Plan. The categories include:

- Tier I category (also called “generic”) includes primarily generic drugs
- Tier II category (also called "formulary brands") includes preferred brand name drugs
- Tier III category (also called "non-formulary brands") includes non-preferred brand name drugs
- Tier IV category (also called “Specialty drugs,”) see description of Specialty drugs below

CVS Caremark's Primary/Preferred Drug list

The CVS Caremark Primary/Preferred Drug list is a list of “preferred” prescription drugs that are identified by the CVS 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.rcbphhealth.com 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 www.caremark.com for a list of the specialty medications formulary.

- **Prior Authorization:** We require prior authorization for certain drugs, such as specialty, weight management and non-preferred (non-formulary) 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 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 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 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 Specialty Pharmacy's clinical team.

Certain specialty self-administered medications will be covered only when purchased through a CVS 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 at 800-237-2767 for the current list of specialty medications covered under the prescription drug benefit when purchased through a CVS Specialty Pharmacy.

Site of Care Management for Specialty Medications

Select clinician-administered specialty medications may be obtained through CVS Specialty Pharmacy and will be covered only under the pharmacy benefit. The CVS Specialty Care Team will work with your providers to determine site of care options, as clinically appropriate. Options may include homecare, ambulatory infusion center or physician's office. Please call CVS Specialty Customer Care at 888-265-7790 for assistance with setting up your prescription.

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 Caremark mail service pharmacy or a CVS Pharmacy to have the prescriptions covered by the Plan.
- There is also a 34-day supply limit for prescriptions that you buy at a non-participating pharmacy. In addition, you are limited to an initial 34-day supply plus two refills for long-term maintenance medications that you buy at a non-participating pharmacy. You pay the full regular price for any prescription that you buy at a non-participating pharmacy and then file a claim with CVS Caremark for reimbursement after you satisfy the annual \$200 prescription drug deductible, if applicable.
- A generic equivalent will be dispensed if it is available. If you receive a prescription for a name brand drug when a FDA 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 generic (Tier 1) copayment.

- You may purchase up to a 90-day supply of a medication through the CVS Caremark mail service prescription program. If you request a refill before you use 75% of the medication or 80% for controlled medications, CVS Caremark will return the refill request to you. CVS Caremark follows generally accepted pharmacy standards when filling your prescriptions. These include Federal and state pharmacy regulations, the professional judgment of the pharmacist, and the usage recommendations of the drug manufacturer as approved by the U.S. FDA. If a FDA approved generic drug is available, CVS Caremark will substitute for a brand name drug. Certain types of prescription medications are not available through the mail service program such as:
 - Specially mixed (compounded) capsules and suppositories
 - Vaccines
 - Frozen medications
 - Dental products
 - Most medical devices
 - Infertility drugs
 - Medications specially wrapped in unit dose packaging

Note: Always request a generic drug from your physician or other prescriber when a generic is available. If a generic equivalent is available, but the pharmacy dispenses the brand name medication, you will pay the difference in cost between the brand name medication and the generic medication plus the generic (Tier I) 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 generic (Tier I) copayment.

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

Medicare Part B coverage: When Medicare Part B is primary, have the pharmacy submit Medicare covered medications and supplies to Medicare first. Prescriptions typically covered by Medicare Part B include diabetes supplies (such as test strips and meters), specific medications used to aid tissue acceptance from organ transplants, and certain oral medications used to treat cancer.

Retail pharmacy: Present your Medicare ID card and ask the pharmacy to bill Medicare as primary. Most independent pharmacies and national chains participate with Medicare. To locate a retail pharmacy that participates with Medicare Part B, visit the Medicare website at www.medicare.gov/supplier/home.asp, or call Medicare Customer Service at 800-633-4227. To maximize your benefits, use a pharmacy that participates with Medicare Part B and is also in our network. When the claim is submitted through coordination of benefits process as a secondary claim through RCBP (this may require submitting a paper claim).

- If you have Medicare Part B as primary, we waive your deductible for prescription drugs and supplies that you buy at a CVS retail participating pharmacy or at a non-participating pharmacy. Additionally, your copayment is reduced for all Caremark mail service prescriptions or for 90-day prescriptions filled at a CVS retail pharmacy.

Note: If Medicare Part B is the primary payor and covers your prescription drugs or diabetic supplies, we waive your deductible and coinsurance for these prescriptions at a network retail pharmacy and waive your copayment at CVS Caremark mail service. 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. No prescription drug can be sold in the U.S. without FDA approval. The manufacturing facilities of all drug companies, whether they make generic or brand name drugs, must pass stringent, regular inspections by the FDA. There is no difference between the standards set for drug companies that make brand name or generic medications. Many drug companies that make brand name drugs also make generic drugs. A generic prescription costs you -- and us -- less than a name brand prescription.

When you do have to file a claim. If you use a CVS Caremark participating pharmacy, the pharmacy will file the claim for you electronically. If you use a non-participating pharmacy, you will need to file a claim with CVS Caremark. Use the CVS Caremark prescription claim form and either file your claim via the Caremark app, www.caremark.com or send your claim to:

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

Claims for prescription drugs and supplies that are not ordered through the CVS Caremark mail service prescription program or a CVS Caremark 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 National Provider Identifiers (NPI), 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.rcbphealth.com.

Benefits Description	You Pay After the calendar year deductible...
<p>Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.</p>	
Covered medications and supplies	High Option
<p>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.</p> <p>You may purchase the following medications and supplies prescribed by a physician from either a retail pharmacy or through the CVS Caremark mail service pharmacy:</p> <ul style="list-style-type: none"> • 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 • Drugs to treat gender dysphoria Note: Certain drugs to treat gender dysphoria are considered Specialty drugs, see <i>Specialty drugs</i> section. • Fertility drugs – three (3) cycles or more Note: Certain drugs to treat infertility are considered Specialty drugs, see <i>Specialty drugs</i> section. • Tobacco cessation drugs and medications. See also Educational classes and programs in Section 5 (a), <i>Medical services and supplies</i> for information about the Plan’s Tobacco Cessation Program • Prescription drugs for weight management 	<p>In-network Retail, up to a 34-day supply:</p> <ul style="list-style-type: none"> • Tier I: 30% of cost; maximum \$7.50 per prescription • Tier II: 30% of cost; maximum \$200 per prescription • Tier III: 30% of cost; maximum \$200 per prescription <p>Out-of-network Retail: 30% of cost</p> <p>CVS Retail Pharmacy or CVS Caremark mail service, up to 90-day supply:</p> <ul style="list-style-type: none"> • 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)

Covered medications and supplies - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Covered medications and supplies (cont.)	High Option
<ul style="list-style-type: none"> Medical foods, as defined by the U.S. Food and Drug Administration, that are consumed or administered enterally and are intended for the specific dietary management of a disease or condition for which there are distinctive nutritional requirements. <p>The Plan covers medical food formulas and enteral nutrition products that are ordered by a healthcare provider and are medically necessary to prevent clinical deterioration in members at nutritional risk.(See Coverage below) Must meet the definition of medical food (see <i>Definitions</i>, Section 10,)</p> <p>Must be receiving active, regular, and ongoing medical supervision and must be unable to manage the condition by modification of diet alone.</p> <p>Coverage is provided as follows:</p> <p>Inborn errors of amino acid metabolism</p> <p>Food allergy with atopic dermatitis, gastrointestinal symptoms, IgE mediation, malabsorption disorder, seizure disorder, failure to thrive, or prematurity, when administered orally and is the sole source (100%) of nutrition. This once per lifetime benefit is limited to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate, in a formula form or powders mixed to become formulas)</p> <p>Note: A prescription is required for medical foods provided under the pharmacy benefit.</p> <p>Note: Prescription drugs for weight management require prior authorization.</p> <p>Note: Colostomy and ostomy supplies are covered under Section 5(a), <i>Durable medical equipment</i>.</p> <p>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.</p> <p>Note: For long-term maintenance medications, you are limited to the initial prescription and two refills at a CVS In-network retail pharmacy or at an Out-of-network retail pharmacy. You must use the CVS Caremark mail service pharmacy or a CVS Pharmacy for a continuing supply of the medication after three fills.</p>	<p>In-network Retail, up to a 34-day supply:</p> <ul style="list-style-type: none"> Tier I: 30% of cost; maximum \$7.50 per prescription Tier II: 30% of cost; maximum \$200 per prescription Tier III: 30% of cost; maximum \$200 per prescription <p>Out-of-network Retail: 30% of cost</p> <p>CVS Retail Pharmacy or CVS Caremark mail service, up to 90-day supply:</p> <ul style="list-style-type: none"> 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)

Covered medications and supplies - continued on next page

Benefits Description	You Pay After the calendar year deductible...
Covered medications and supplies (cont.)	
<p>Drugs and diabetic supplies (including insulin), when Medicare Part B is the primary payer.</p> <p>Note: You must show your Medicare ID card at the pharmacy when purchasing these items and Medicare must pay first in order to receive the maximum benefit.</p>	<p>Nothing (No deductible)</p>
<p>Specialty drugs are used to treat gender dysphoria, chronic complex conditions and require special handling and close monitoring and must be obtained from CVS Specialty Pharmacy.</p> <p>Note: Preauthorization is required. Call CVS Specialty Pharmacy at 866-814-5506 for more information</p>	<p>CVS Caremark Specialty Pharmacy 30-day supply:</p> <ul style="list-style-type: none"> • Tier IV: \$70 Specialty generic drugs (No deductible) • Tier V: \$90 Specialty preferred brand drugs (No deductible) • Tier VI: \$120 Specialty non-preferred brand drugs (No deductible) <p>CVS Caremark Specialty Pharmacy 90-day supply:</p> <ul style="list-style-type: none"> • Tier IV: \$100 Specialty generic drugs (No deductible) • Tier V: \$125 Specialty preferred brand drugs (No deductible) • Tier VI: \$250 Specialty non-preferred brand drugs (No deductible)
<p>Narcan (rescue agent)</p> <p>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.</p>	<p>In-Network Retail: Nothing (No deductible)</p> <p>Out-of-network Retail: Nothing (No deductible)</p> <p>CVS Caremark mail service: Nothing (No deductible)</p>
<p>Over-the-counter (OTC) nicotine replacement therapy or prescription drugs approved by the FDA to treat and nicotine dependence. A doctor's written prescription is required. See also Educational classes and programs in Section 5(a), <i>Medical services and supplies</i> for information about the Plan's Tobacco Cessation Program.</p>	<p>In-Network Retail: Nothing (No deductible)</p> <p>Out-of-network Retail: Nothing (No deductible)</p> <p>CVS Caremark mail service: Nothing (No deductible)</p>
Preventive care medications	
<ul style="list-style-type: none"> • Medications to promote better health as recommended by ACA and the U.S. Preventive Services Task Force (USPSTF) with a rating of "A" or "B" • CVS Caremark ACA No-Cost Preventive Services List <p>Drugs and supplements on the lists are covered even if they are listed as over-the-counter. Your doctor must write a prescription for these preventive services and they must be filled at a network pharmacy.</p>	<p>In-network Retail: Nothing</p> <p>Out-of-network Retail: All Charges</p>

Preventive care medications - continued on next page

Benefits Description	You Pay After the calendar year deductible...
High Option	
<p>Preventive care medications (cont.)</p> <p>Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) with a rating of “A” or “B” is available online at www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations.</p> <p>Note: A complete list of CVS Caremark No-Cost preventive care services is available online at www.caremark.com.</p>	<p>In-network Retail: Nothing</p> <p>Out-of-network Retail: All Charges</p>
<p>Contraceptive drugs and devices as listed in the ACA/HRSA site, coverage includes:</p> <ul style="list-style-type: none"> • Oral contraceptives • Emergency Contraceptives • Injectable Contraceptives • Miscellaneous Contraceptives —Intrauterine Devices, Subdermal Rods & Vaginal Rings • Contraceptive transdermal patches • Barrier Methods- Cervical Caps and Diaphragms • OTC—Contraceptives (requires prescription) • Vaginal pH Modulators <p>Call us at 800-292-4182 for our contraceptive exception process or for information on our reimbursement for OTC contraceptives (prescription required).</p>	<p>In-Network Retail: Nothing (No deductible)</p> <p>Out-of-network Retail: Nothing (No deductible)</p> <p>CVS Caremark mail service: Nothing (No deductible)</p>
High Option	
<p>Not covered</p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to treat impotence and sexual dysfunction</i> • <i>Medical foods and nutritional supplements, except as described in Section 5(a), Durable medical equipment</i> • <i>Nonprescription (over-the-counter) medications, except as noted above</i> 	<p><i>All Charges</i></p>

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*.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of \$75 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

Benefit Description	You pay
<p>Accidental injury benefit</p> <p>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).</p> <p>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.</p> <p>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.</p>	<p>High Option</p> <p>In-network: 10% of Plan allowance (No deductible)</p> <p>Out-of-network: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)</p>

Dental benefits	Dental Benefit Class A Schedule
Service	High Option
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	High Option
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
Restorations - 2 surface permanent	\$20.50
Restorations - 3 or more surface permanent	\$26.50
Restorations - Gold restoration	\$103.50
Extractions - Single tooth	\$16.00
Extractions - Pulp capping-direct	\$9.50
Extractions - Pulpotomy-vital	\$21.00
Root canal therapy - one root This includes the actual root canal treatment and any replacements	\$106.00
Root canal therapy - Two roots This includes the actual root canal treatment and any replacements	\$126.00
Root canal therapy - Three or more roots This includes the actual root canal treatment and any replacements	\$170.00
Periodontics - Periodontal scaling and root planning	\$26.50
Crowns/abutments - Resin and Resin with metal	\$120.00
Crowns/abutments - Porcelain	\$113.50
Crowns/abutments - Porcelain with gold	\$120.00
Crowns/abutments - Gold (full cast and 3/4 cast)	\$120.00
Crowns/abutments - Prefabricated resin and stainless steel	\$21.50
Pontics - Porcelain and Porcelain with gold	\$120.00
Dentures - Complete upper and lower	\$126.00
Dentures - Partial without bar	\$138.00

Service - continued on next page

Dental benefits	Dental Benefits Class B Schedule
Service (cont.)	High Option
Dentures - Partial with bar	\$157.00
Dentures - Repairs (dentures and partials)	\$14.00
Dentures - Denture relining	\$40.50

Section 5(h). Wellness and Other Special Features

Special feature	Description
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • 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 <i>OPM disputed claims process</i> (see Section 8).
<p>Institutes of Excellence (IOE)</p>	<p>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.</p> <p>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 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.</p> <p>Reimbursement is subject to IRS regulations.</p> <p>Note: Receipts are required for reimbursement of travel and lodging costs.</p> <p>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.</p>
<p>Gene-Based, Cellular and Other Innovative Therapies (GCIT) Designated Network</p>	<p>The Plan has special agreements with facilities to provide services and supplies related to GCIT™. The GCIT Designated Network was designed to provide high quality medical care for patients who have been diagnosed with certain genetic conditions.</p> <p>Note: If a qualified gene therapy service is medically necessary, performed at one of the GCIT facilities and the Plan is the primary payor, you may be eligible for reimbursement of some expenses for travel and lodging for the gene therapy recipient and one family member or caregiver. If the gene therapy recipient is 21 or younger, we may pay eligible travel costs for the patient and two caregivers.</p> <p>Reimbursement is subject to IRS regulations.</p> <p>Note: Receipts are required for reimbursement of travel and lodging costs.</p>

	<p>See Section 5(a), <i>Treatment therapies</i> and Section 5(c), <i>Outpatient hospital or ambulatory surgical center</i> for the Plan’s gene therapy benefit.</p> <p>Contact the Plan at 800-638-8432 for more information. We are available to assist you Monday through Friday from 6:00 a.m. to 5:00 p.m. Mountain Standard Time (MST).</p>
Cancer treatment benefit	<p>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.</p>
Kidney (renal) dialysis benefit	<p>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.</p>
Services for deaf and hearing impaired	<p>No benefit, except as shown in Section 5(a), <i>Hearing services</i>.</p>
24-Hour Nurse Line	<p>24-Hour Nurse Line provides eligible members with phone access to registered nurses experienced in providing information on a variety of health topics. 24-Hour Nurse 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. 24-Hour nurses cannot diagnose, prescribe medication or give medical advice.</p> <p>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.</p> <p>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.</p> <p>24-Hour Nurse 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.</p>
Healthy Maternity Program	<p>You have access to Aetna's Healthy Maternity Program to support you on your maternity journey. Our Healthy Maternity Program provides trusted information and guidance about family planning, support and postpartum care.</p> <p>With this program, you will also have access to the following resources:</p> <ul style="list-style-type: none"> • Nurses who are trained in obstetrics and high-risk pregnancy conditions. • Behavioral health support, including referrals to resources to deal with stress, depression, and anxiety • Postpartum depression screening and support • Resources and educational materials through our Maternity Support Program • Guided medically appropriate genetic counseling and testing • Preeclampsia prevention – If you are identified as high-risk, you will receive educational materials about preeclampsia risk factors, and the benefits of aspirin therapy. • Fertility advocate to help you throughout your infertility journey, fertility preservation, same-sex conception needs, and more. The advocate will also provide support and guidance during fertility treatment and provide support if you become pregnant. For direct access to a fertility advocate, call 833-415-1709.

	<p>No matter where you are on your journey, our nurses and experts are here to support you along the way. Participation in this program is voluntary and available at no cost to you. The participant and their physician or healthcare provider remain in charge of the participant's treatment plan. If you would like more information or would like to enroll in the Healthy Pregnancy Program, contact the Plan at 855-282-6344.</p>
<p>Complex and Chronic Disease Management Program</p>	<p>AccordantCare offers programs for the following complex chronic medical conditions:</p> <ul style="list-style-type: none"> • 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) • Pulmonary Arterial Hypertension (PAH) <p>For more information on the AccordantCare programs, please call toll-free 866-380-6295.</p>
<p>Care Management Program</p>	<p>For your health needs and concerns, RCBP offers several resources through our Care Management Program to assist you with your care coordination for acute and/or chronic condition(s). This program provides education, clinical support, and access to support and well-being tools to help you better manage your health.</p> <p>Our Care Management Program offers:</p> <ul style="list-style-type: none"> • 1:1 support with a clinical nurse who can help you: <ul style="list-style-type: none"> - Assistance in developing a plan to address your specific health needs and achieve your goals - To help you understand your benefit offerings - To answer your health-related questions • Group Coaching • Digital support • Customized health action plans based on your needs and preferences • Personalized communications to assist you with making informed health decisions <p>To start using our digital support tools, log in to the Aetna member website from RCBPhealth.com. First-time users will need to register.</p>

	<p>We offer several digital health and wellness related programs and resources:</p> <ul style="list-style-type: none"> • 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 healthcare 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. • Additional member resources such as: Cancer Support, Joint Pain Support, and Maternity Support. <p>Our Care Management Program includes the following programs and services. For more information about our Care Management Program or services, please call 800-638-8432 and select the correct prompt. We are available to assist you Monday-Friday from 6:00 a.m. to 5 p.m. Mountain Time (MST).</p>
<ul style="list-style-type: none"> • Back & Joint Care 	<p>Provides digital support for members dealing with musculoskeletal (MSK) issues, acute and chronic pain, and either taking opioids or trying to avoid opioids. The program helps you improve your quality of life by helping you manage and reduce your chronic MSK pain, without surgery or drugs. If RCBP identifies that there is an opportunity to help you improve your care, you will be invited to participate. Eligible participants will receive access to exercise therapy, motivational coaching, 1:1 support and education that is tailored to the participant’s specific needs.</p>
<ul style="list-style-type: none"> • Behavioral Health Support 	<p>RCBP provides resources and support to help you address mental health or behavioral health conditions like anxiety, depression, substance use disorders, domestic violence and more. Our team will work with you, help you understand your benefits and guide you through the wellness programs we offer. We are here to support you, get you connected with a clinical social worker, psychologist or other behavior health professional to obtain the right treatment, the best services and resources to manage the daily obstacles that may be keeping you from achieving a healthier happy life.</p>
<ul style="list-style-type: none"> • Cancer Support 	<p>Provides dedicated proactive support to individuals along their cancer journey. We understand that a cancer diagnosis is life changing and can be overwhelming, and we are here to help you. Through our program, individuals will better understand their benefits, have the ability to locate the right provider for their specific need and get certain services approved. Individuals will also receive care management support for holistic care, treatment side effects, and medication management.</p>
<ul style="list-style-type: none"> • Compassionate Care 	<p>Offers you service and support when you or a family member have a serious illness or face imminent end-of-life decisions. The program provides you tools and information to encourage advanced 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.</p>
<ul style="list-style-type: none"> • Healing Better 	<p>Provides support and educational resources for total knee or hip replacement surgery. The program gives you the tools and resources you need to prepare for a successful surgery and healthy recovery. It provides you access to benefit information specific to joint services, holistic overview of pain management options, digital, personalized education on recovery resources, mental and physical health tips and more.</p>

<ul style="list-style-type: none"> • Social Work 	<p>Is designed to assist you in improving your 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 you services in times of need. Some examples include:</p> <ul style="list-style-type: none"> • Local food pantries • Utility or rental assistance programs • Home-delivered meal services • Support groups • Counseling services • Federal and state programs <p>Our social workers are licensed and degreed professionals with experience in a variety of settings, including government and non-profit organizations, hospitals, schools and clinics.</p>
<ul style="list-style-type: none"> • Transform Diabetes Care 	<p>Helps members keep their diabetes and hypertension in check. The program uses medical claims, pharmacy claims, biometric screening data, and lab results to identify opportunities to help members improve their health. Members are provided personal guidance in five areas of focus: medication adherence, taking the right medication, self-monitoring of blood glucose and blood pressure, lifestyle and comorbidity management and recommended screenings, which all are based on the member’s specific needs. You do not need to enroll in this program. If RCBP identifies there is an opportunity to help you improve your care, we will contact you by phone, letter, email, or even in person by a CVS pharmacist or MinuteClinic provider.</p>
<p>Lab Savings program</p>	<p>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.</p> <p>The Lab Savings program is an optional program. If you or your provider chooses not to participate in the Lab Savings Program, you will not be penalized. You will simply receive the regular Plan benefit for lab tests (see page 35).</p> <p>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).</p> <p>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.</p> <p>For Lab Savings program services, please call Quest Diagnostics at 866-697-8378 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.</p>
<p>Pharmacy Advisor Program</p>	<p>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.</p> <ul style="list-style-type: none"> • Diabetes • Congestive Heart Failure (CHF) • Coronary Artery Disease (CAD) • Hypertension (high blood pressure) • Dyslipidemia (high cholesterol)

	<ul style="list-style-type: none"> • Asthma • Chronic obstructive pulmonary disease (COPD) • Depression • Osteoporosis • Breast cancer
<p>Aetna member website</p>	<p>Aetna member website - Secure Member Portal</p> <p>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.</p> <p>The Aetna member website provides tools to become an optimal healthcare consumer. Services such as the following are available:</p> <ul style="list-style-type: none"> • 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, healthcare 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.
<p>Aetna Health App</p>	<p>After registration/log-in you can use the Aetna Health app to:</p> <ul style="list-style-type: none"> - 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) <p>The app can be downloaded for free onto your mobile device.</p> <p>How to Access:</p> <ul style="list-style-type: none"> • Android: Go to Play Store and search for Aetna Health. • iPhone: Go to App Store and search for Aetna Health.

	<ul style="list-style-type: none"> • Text "Aetna" to 90156 to receive a link to download the Aetna Health app (message and data rates may apply) <p>Supported Devices:</p> <ul style="list-style-type: none"> • Android • iPhone®
<p>Wellness Incentive</p>	<p>Members (18 years of age and over, except well-child visits for children up to 15 months) who participate in the Wellness Incentive programs can earn up to \$400 in rewards per calendar year.</p> <p>Complete the Health Risk Assessment (HRA) and \$50 will be deposited on a PayFlex® debit card to use for certain 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.</p> <p>Complete a biometric screening through Quest Diagnostics or LabCorp by November 30th of the calendar year and \$100 will be deposited on a PayFlex debit card to use for certain eligible medical expenses. You can obtain the biometric screening at a Quest Diagnostics Patient Service Center (PSC), through your physician by having your physician complete a Biometric Screening Physician Results Form and fax it back by the date above or through an at-home collection materials. To register for your screening or request an at-home collections materials call 855-623-9355 or to print a copy of the Biometric Screening Physician Results Form to take to your physician, visit www.My.QuestforHealth.com and enter the registration key: RCBP.</p> <p>Once your biometric screening is complete, your results will be available at www.My.QuestforHealth.com and will also be mailed to you to help you better understand your health risks.</p> <p>You can also obtain your biometric screening at a LabCorp Patient Service Center (PSC), through your physician by having your physician complete a Biometric Screening Physician Results Form and fax it back to LabCorp by the date above or through at home collection materials. For more information on how to register for your LabCorp screening or to request at-home collections materials visit www.rcbphealth.com/wellness-rewards.</p> <p>Once your biometric screening is complete, your results will be available on LabCorp's portal.</p> <p>Members with the following conditions may be eligible to earn up to \$100 for each incentive to be deposited on a PayFlex debit card:</p> <ul style="list-style-type: none"> • Controlling Blood Pressure for members with high blood pressure <p>If you are identified as having high blood pressure, we 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.</p> <p>If you are unable to meet this goal, you will receive the incentive if one of the following is completed:</p> <ul style="list-style-type: none"> 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 and Stress Management).

• **Controlling A1c Hemoglobin (HbA1c) levels for members with diabetes**

If you are identified as having diabetes, ask your provider to 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 healthcare provider with respect to the frequency of use and glucose testing.

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

• **Well-child visits for children**

If you have a child, your child must complete six (6) or more well-child visits with a primary care provider within the first 15-months of their life. The well-child visits must occur on different dates of service and six visits must be completed on or before your child's 15-month birthday. The Plan may request your primary care provider's information or documentation to earn the wellness 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 31st of the calendar year to: Rural Carrier Benefit Plan C/O Wellness Incentive, P.O. Box 14079, Lexington, KY 40512-4079.

Complete any of the following Healthy Actions to earn additional incentives:

- Get your breast cancer screening and earn \$100
- Get your cervical cancer screening (pap smear) and earn \$100
- Get your colorectal cancer screening and earn \$100
- Participate in our Telephonic Health Coaching Program and complete 6 coaching sessions (see elsewhere in this section) and earn \$75

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.

	<p>After you have completed a wellness activity, the Plan will deposit the amount earned on your PayFlex debit card, at which time you will receive your reloadable PayFlex debit card. Any future wellness incentives will be loaded on the same card. Please allow at least 4 weeks after completing a wellness activity for incentives earned to be deposited. You can use your PayFlex debit card to pay for certain unreimbursed medical expenses such as deductible, coinsurance, copays and other eligible medical expenses approved by the IRS. To monitor the funds on your PayFlex debit card, call the number on the back of your PayFlex debit card, or visit www.Payflex.com. If you are enrolled in a Flexible Spending Account (FSA) and wellness incentives are deposited to a PayFlex card, you may not receive reimbursement from both FSA and PayFlex. 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.</p> <p>If you have any questions or would like more information about the program, please call customer service at 800-638-8432.</p>
<p>Comprehensive Pain Management Program</p>	<p>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.</p> <p>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.</p> <p>RCBP is leveraging multiple vender partners to provide the infrastructure and 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.</p> <p>Want more information about the Comprehensive Pain Management Program? Contact TrestleTree directly at 855-553-5109.</p> <p>We also have an Opioid Support Program through TrestleTree. See elsewhere in this Section under Telephonic Health Coaching Program.</p>
<p>Telephonic Health Coach Program</p>	<p>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:</p> <ul style="list-style-type: none"> • Tobacco Cessation • Weight Management • Exercise • Nutrition • Stress Management • Opioid Support Program <p>How does health coaching work?</p>

	<ul style="list-style-type: none"> • 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. <p>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).</p> <p>Note: See Section 5(a), <i>Educational classes and programs</i> for more information.</p>
<p>Health Risk Assessment</p>	<p>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:</p> <ul style="list-style-type: none"> • 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 <p>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 enroll.trestletree.com (passcode: RCBP).</p>
<p>Telehealth</p>	<p>RCBP offers access to Teladoc® telehealth consultations any time, 24/7/365 that is easy to use, private and secure. Teladoc is the nation’s leading virtual care provider with over 3,600 board certified, state-licensed, primary care providers, pediatricians and specialists that have on average 20 years of experience and are available by web, phone and the Teladoc mobile app. With Teladoc, you can take care of most common issues such as: cold & flu symptoms, allergies, cough, sinus infection, respiratory infection, eye infection, skin problems and more. You can also see a therapist for ongoing counseling for concerns such as: depression, anxiety, stress, as well as for diet and nutrition assistance.</p> <p>How to sign up:</p> <ol style="list-style-type: none"> 1. Download the iOS or Android App by searching “Teladoc” 2. Sign-up on the web at www.teladoc.com/Aetna 3. Sign-up by phone, call 855-835-2362 (855-Teladoc) <p>Note: Teladoc does not replace your primary care provider. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulations, see below. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services.</p> <p>General Medical (via phone and video): Our general medical service is available in all 50 states, including D.C., and 4 U.S. territories (Puerto Rico, Guam, US Virgin Islands, Northern Mariana Islands).</p> <p>Dermatology (via phone and video): Our dermatology service is available in all 50 states, including D.C.</p> <p>Nutritional (via phone and video): Our nutritional service is available in all 50 states, including D.C.</p>

	<p>Mental Health Care (via video only): Our mental health service is available in all 50 states, including D.C.</p> <p>If you have any questions or would like more information about the program, please call us at 800-638-8432.</p>
<p>Value Added Programs and Services</p>	<p>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.</p>
<p>Digital (online) Coaching Program</p>	<p>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.</p> <p>This provides you secure access to a broad range of your personal health information after you register.</p> <p>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”.</p>

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% to 60% 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 27,000 providers at over 110,000 locations including optometrists, ophthalmologists, opticians and leading optical retailers such as: LensCrafters, participating Pearle Vision, Target Optical, and many independent providers.

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.

LifeMart Member Discount Program - Get access to hundreds of exclusive discounts on products and services nationwide, including dental and vision care, fitness gear, nutrition, gyms and more from one convenient location! Plus, download the LifeMart mobile app for savings on the go. To access these discounts go to www.RCBPHealth.com, click on Aetna secure member website and login, then click on the "Health & Wellness" tab.

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, 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) or State premium taxes however applied;
- Custodial care;
- 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 severe 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 telephone or online consultations and/or therapy and associated services, such as transmission fees, care plan oversight, emails, or patient monitoring or physician standby services billed by a healthcare provider;
- Membership or concierge service fees charged by a healthcare provider;
- 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, except as described in Section 5(a), *Orthopedic and prosthetic services* and Section 5(b), *Gender affirming surgery*;
- Eyeglasses or contact lenses (except as covered under *Vision services* in Section 5(a); or
- Services and supplies not specifically listed as covered;
- Services or supplies we are prohibited from covering under the Federal Law.

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 provider 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.

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

Records

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

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three-year limitation on 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.** If you have questions about the processing of overseas claims, contact us at 800-638-8432.

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 healthcare 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 ten percent (10%) 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 healthcare 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 healthcare 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 their 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	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> 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. <p>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.</p>
2	<p>In the case of a post-service claim, we have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim or b) Write to you and maintain our denial. c) Ask you or your provider for more information.

	<p>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.</p> <p>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.</p>
<p>3</p>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"> • 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. <p>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.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • 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. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p> <p>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 healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<p>4</p>	<p>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 or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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 family member 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 healthcare 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 processes the benefit, 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 healthcare 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 or employing 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

Every job-related injury or illness should be reported as soon as possible to your supervisor. Injury also means any illness or disease that is caused or aggravated by the employment as well as damage to medical braces, artificial limbs and other prosthetic devices. If you are a federal or postal employee, ask your supervisor to authorize medical treatment by use of form CA-16 before you obtain treatment. If your medical treatment is accepted by the Dept. of Labor Office of Workers’ Compensation (OWCP), the provider will be compensated by OWCP. If your treatment is determined not job-related, we will process your benefit according to the terms of this plan, including use of in-network providers. Take form CA-16 and form OWCP-1500/HCF-1500 to your provider, or send it to your provider as soon as possible after treatment, to avoid complications about whether your treatment is covered by this plan or by OWCP.

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.

• 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 or employing 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@estprs.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 they were 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 healthcare. 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 as 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-Deductible

High Option You pay without Medicare In-Network: \$350/\$700
High Option You pay without Medicare Out-of-network: \$800/\$1600
High Option You pay with Medicare In-network: N/A
High Option You pay with Medicare Out-of-network: N/A

Benefit Description - Catastrophic Protection Out of pocket maximum

High Option You pay without Medicare In-Network: \$5,000/\$10,000
High Option You pay without Medicare Out-of-network: \$7,000/\$14,000
High Option You pay with Medicare In-network: \$5,000/\$10,000
High Option You pay with Medicare Out-of-network: \$7,000/\$14,000

Benefit Description - Part B premium reimbursement offered

High Option You pay without Medicare In-Network: N/A
High Option You pay without Medicare Out-of-network: N/A
High Option You pay with Medicare In-network: N/A
High Option You pay with Medicare Out-of-network: N/A

Benefit Description - Primary care provider

High Option You pay without Medicare In-Network: \$20 copay
High Option You pay without Medicare Out-of-network: 30% of Plan allowance and any difference after deductible
High Option You pay with Medicare In-network: Nothing
High Option You pay with Medicare Out-of-network: Nothing

Benefit Description - Specialist

High Option You pay without Medicare In-Network: \$35 Copay
High Option You pay without Medicare Out-of-network: 30% of Plan allowance and any difference after deductible
High Option You pay with Medicare In-network: Nothing
High Option You pay with Medicare Out-of-network: Nothing

Benefit Description - Inpatient Hospital

High Option You pay without Medicare In-Network: \$200 copay per admission
High Option You pay without Medicare Out-of-network: \$400 copay per admission and any difference after deductible. The \$400 does not apply to out-of-network hospital admissions for mental health and/or substance use disorders.
High Option You pay with Medicare In-network: Nothing
High Option You pay with Medicare Out-of-network: Nothing

Benefit Description - Outpatient Hospital

High Option You pay without Medicare In-Network: 15% of Plan's allowance after calendar year deductible
High Option You pay without Medicare Out-of-network: 30% of Plan allowance and any difference after calendar year deductible
High Option You pay with Medicare In-network: Nothing
High Option You pay with Medicare Out-of-network: Nothing

Benefit Description - Incentives Offered

High Option You pay without Medicare In-Network: N/A
High Option You pay without Medicare Out-of-network: N/A
High Option You pay with Medicare In-network: N/A
High Option You pay with Medicare Out-of-network: 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 healthcare 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 our Medicare Advantage Plan: You may enroll in Rural Carrier Benefit Plan and our national **Aetna Medicare Advantage for Rural Carrier Benefit Plan** if you are an annuitant or former spouse with primary Medicare Parts A and B. Enrollment in the Aetna Medicare Advantage for Rural Carrier Benefit Plan is voluntary. Our Medicare Advantage plan will enhance your FEHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage for Rural Carrier Benefit Plan is subject to Medicare rules. You can enroll in our Medicare Advantage plan with no additional premium. If you are already enrolled and would like to understand your additional benefits in more detail, please call us at 866-241-0262, 8 a.m. to 5:30 p.m., Monday through Thursday or 8:30 a.m. to 5:30 p.m. on Fridays (Eastern standard time), go to www.aetnaretireehealth.com/rcbp, or you may also refer to your Medicare plan's Evidence of Coverage. Once you enroll in our Aetna Medicare Advantage for Rural Carrier Benefit Plan, we will send you additional information.

When you are enrolled in the Rural Carrier Benefit Plan under the FEHB Program and Aetna Medicare Advantage for Rural Carrier Benefit Plan members receive the following enhanced benefits. Please note that Aetna Medicare Advantage features may vary by location or region.

- No deductible
- No copays or coinsurance for covered services (office visits or telehealth, preventive care, surgical care, inpatient/outpatient hospital care, emergency room/urgent care, etc.)
- Catastrophic Protection Out-of-Pocket Maximum of \$2,000 per person annually
- Prescription drug copay or coinsurance per 30-day supply - Generic copays of \$0 Preferred Pharmacies, \$2 Standard Pharmacies, \$5 all other pharmacies; Preferred Brand \$35; Non-Preferred Brand \$40; and Specialty \$70
- Additional benefits such as non-emergency transportation program, SilverSneakers® (a registered trademark of Tivity Health Inc.), Resources for Living, meal benefit delivery program following inpatient hospitalization, etc.

Part B Premium Reduction

We will reduce the Part B premium that you pay to the Social Security Administration by \$75 per month. If you pay your Part B premium on a monthly basis, you will see this dollar amount credited in your Social Security check. If you pay your Part B premium quarterly, you will see an amount equaling three months of reductions credited on your quarterly Part B premium statement. It may take a few months to see these reductions credited to either your Social Security check or premium statement, but you will be reimbursed for any credits you did not receive during this waiting period.

The Medicare Income-Related Monthly Adjustment Amount (IRMAA) is an amount you pay in addition to your Part B and D premium if your income is above a certain level. Social Security makes this determination based on your income. For additional information concerning the IRMAA, contact the Social Security Administration.

Important Information on Enrollment in our Aetna Medicare Advantage for Rural Carrier Benefit Plan

Aetna Medicare Advantage for Rural Carrier Benefit Plan is a Medicare contract separate from the FEHB RCBP High Option Plan and depends on contract renewal with CMS. Contact us for a copy of the Evidence of Coverage for the Aetna Medicare Advantage for Rural Carrier Benefit Plan. You may also obtain a copy of the Evidence of Coverage at the following link, www.rcbphealth.com/retiree. The Evidence of Coverage contains a complete description of plan benefits, exclusions, limitations and conditions of coverage under Medicare Advantage for Rural Carrier Benefit Plan.

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.

Individual Medicare Part D coverage: If you are currently enrolled in an individual Medicare Part D Plan, your enrollment into the SilverScript PDP for Rural Carrier Benefit Plan will result in your disenrollment from that plan. You cannot be covered under two Part D plans at the same time. If you elect to opt out of the SilverScript PDP for Rural Carrier Benefit Plan and remain in your individual Medicare Part D plan, your FEHB prescription drug coverage will be secondary to your individual Medicare Part D Plan. In that circumstance, the Plan will supplement the coverage you get under your Medicare Part D prescription drug plan. We will not waive any copayments or coinsurance when you have Medicare Part D as your primary payor. To maximize your benefits, use a pharmacy that is in both the Medicare Part D plan's network, and in our network. Provide both your Medicare Part D and RCBP ID cards when filling a prescription allowing the pharmacy to coordinate coverage on your behalf.

- **Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP)**

If you are enrolled in Medicare, and are not enrolled in a Medicare Advantage Plan (Part C), you will be automatically enrolled in the Medicare Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). The PDP EGWP is a prescription drug benefit for FEHB covered annuitants and their FEHB covered family members who are eligible for Medicare. This allows you to receive benefits that will never be less than your coverage that is available to members with only FEHB but more often you will receive benefits that are better than members with only FEHB.

This Plan and our PDP EGWP: You will be automatically enrolled in our PDP EGWP and continue to remain enrolled in our FEHB Plan. Participation in the PDP EGWP is voluntary, and **you have the choice to opt out of this enrollment at any time.**

In the case of those with higher incomes you may have a separate premium payment for your PDP EGWP benefit. Please refer to the Part D- Income-Related Monthly Adjustment Amount (IRMAA) section of the Medicare website: www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.

We offer SilverScript Employer Prescription Drug Plan (PDP) for Rural Carrier Benefit Plan, a Medicare Employer Group Waiver Plan (EGWP) to Medicare-eligible annuitants and Medicare eligible family members covered under the Plan. The PDP is a Medicare Part D plan and members will pay lesser or equal copays which means benefits will never be lesser than your coverage that is available to members with only FEHB coverage. More often, you will receive benefits that are better than members with only FEHB. Covered drugs will be subject to the formulary approved by the Centers for Medicare and Medicaid Services.

If you are an annuitant or an annuitant's family member who is enrolled in either Medicare Part A or B or Parts A and B, and are not enrolled in our Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan members, you will be automatically enrolled in SilverScript effective January 1, 2024, or later upon becoming Medicare-eligible. There is no need for you or your eligible dependent to take action to enroll. If you do not wish to enroll in the SilverScript Employer PDP for Rural Carrier Benefit Plan, you may "opt out" of the enrollment by following the instructions mailed to you or by calling us at 833-825-6754. Declining coverage or "opting out" will place you back into your FEHB prescription drug coverage. You can opt out at any time.

We will pay the Medicare premium for this Part D drug plan coverage except any additional premium imposed due to exceeding the income threshold as defined by the Social Security Administration, such as IRMAA.

Participants who enroll in SilverScript Employer PDP for Rural Carrier Benefit Plan will receive a separate SilverScript prescription ID card to use for filling prescriptions. The following are your enhanced prescription benefits:

- No prescription deductible
- Catastrophic Protection Out-of-Pocket Maximum of \$2,000 per person annually (included in the Plan's integrated medical and prescription drug overall out of pocket maximum.)
- **Prescription drug copay per 30-day supply:** Generic \$5; Preferred Brand \$40; Non-Preferred Brand \$50; and Specialty \$70
- **Prescription drug copay per 90-day supply:** Generic \$10; Preferred Brand \$40; Non-Preferred Brand \$70; and Specialty \$100

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		✓*
9) Are a Federal employee receiving 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:

Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,

Then you are responsible for:

your deductibles, coinsurance, and copayments.

If your physician:

Participates with Medicare and is not in our PPO network,

Then you are responsible for:

your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount.

If your physician:

Does not participate with Medicare,

Then you are responsible for:

your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

If your physician:

Does not participate with Medicare and is not a member of our PPO network

Then you are responsible for:

your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount

If your physician:

Opts-out of Medicare via private contract

Then you are responsible for:

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 they have 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.
Assignment	<p>An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.</p> <ul style="list-style-type: none">• We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.• Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.• OPM's contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.
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	<p>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.</p> <p>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:</p> <ul style="list-style-type: none">• 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 24.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 24.

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	<p>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:</p> <ul style="list-style-type: none"> • 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. <p>We determine what treatments or services is custodial care.</p>
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 24.
Experimental or investigational services	<p>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.</p> <p>A medical treatment or procedure, or a drug, device or biological product is experimental or investigational if:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>
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.
Healthcare professional	A physician or other healthcare professional licensed, accredited, or certified to perform specified health services consistent with state law.
Home healthcare agency	A public agency or private organization under Medicare that is licensed as a home healthcare agency by the State and is certified as such.

Home healthcare 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 healthcare, confinement in a hospital or skilled nursing facility would be required.

Infertility Infertility is defined when a person is unable to conceive or produce conception after 1 year of egg sperm contact when the female (or individual with female reproductive organs) attempting conception is under 35 years of age, or after 6 months of egg-sperm contact when the individual attempting conception is 35 years or older. Egg-sperm contact can be achieved by sexual intercourse or through attempted egg-sperm insemination (intrauterine, intracervical, or intravaginal). This definition applies to all individuals regardless of sexual orientation or the presence/availability of a partner. Infertility may also be established by the demonstration of a disease of the reproductive tract such that regular egg-sperm contact would be ineffective.

The Plan covers three levels of infertility – Basic Infertility, Comprehensive Infertility and Advanced Reproductive Technology (ART). Under Comprehensive Infertility and ART, members undergo treatments in cycles.

- The Plan defines a cycle for Comprehensive Infertility as an attempt at ovulation induction while on injectable medication to stimulate the ovaries with or without artificial insemination; or an artificial insemination cycle with or without injectable medication to stimulate the ovaries.
- The Plan defines a cycle for ART as one complete fresh IVF cycle with transfer (egg retrieval, fertilization, and transfer of embryo), one complete GIFT cycle, or one complete ZIFT cycle.

See our medical clinical policy bulletin under Section 10, *Definitions of Terms We Use in This Brochure - Medical Necessity* definition for additional details on Aetna's Infertility Clinical Policy.

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 healthcare services that we determine are appropriate to diagnose or treat your condition, illness, or injury and that:

- are consistent with standards of good medical practice in the United States;
- are clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and
- 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.

Note: When a medical necessity determination is made utilizing the Aetna Clinical Policy Bulletins (CPBs), you may obtain a copy of the CPB through the Internet at: www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html.

**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 other participating providers, 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.

You should also see *Important Notice About Surprise Billing – Know Your Rights* in Section 4 that describes your protections against surprise billing under the No Surprises Act.

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	<p>Preventive services:</p> <ul style="list-style-type: none">• 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 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. <p>Immunizations:</p> <ul style="list-style-type: none">• We cover routine adult and childhood 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.
Surprise bill	An unexpected bill you receive for <ul style="list-style-type: none">• emergency care – when you have little or no say in the facility or provider from whom you receive care, or for• non-emergency services furnished by nonparticipating providers with respect to patient visits to participating health care facilities, or for• air ambulance services furnished by nonparticipating providers of air ambulance services.
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: <ul style="list-style-type: none">• 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.
Walk-in clinic	A medical facility that accepts patients on a walk-in basis; no appointment is required. Provides non-emergency, basic healthcare services on a walk-in basis. Examples include MinuteClinic® at CVS Pharmacy locations and Healthcare Clinics in Walgreens pharmacy locations. Urgent care clinics are not considered walk-in clinics.
You	You refers to the enrollee and each covered family member.

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

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Summary of Benefits for the High Option of the Rural Carrier Benefit Plan- 2024

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.rcbphhealth.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 a double asterisk (**) means the item is subject to the \$200 prescription drug deductible. 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 healthcare professional.

High Option Benefits	You pay	Page
Medical services provided by physicians: Diagnostic and treatment services provided in the office	<p>In-network primary care provider: \$20/office visit</p> <p>In-network specialist provider: \$35/office visit</p> <p>Out-of-network: 30% of our allowance* and any difference between our allowance and the billed amount</p>	32
Medical services provided by physicians: Surgery	<p>In-network: 15% of our allowance</p> <p>Out-of-network: 30% of our allowance* and any difference between our allowance and the billed amount</p>	53
Medical services provided by physicians: Telehealth	<p>In-network: Nothing if you contact Teladoc for services</p> <p>Out-of-network: No benefit</p>	34
Medical services provided by physicians: Telehealth	<p>In-network: \$20/office visit for primary care services; \$35/office visit for specialist care services</p> <p>Out-of-network: 30% of the Plan allowance* and any difference between our allowance and the billed amount</p>	32
Services provided by a hospital: Inpatient	<p>In-network: \$200 copayment per admission (waived for maternity stay)</p> <p>Out-of-network: \$400 copayment per admission; 30% of covered charges</p>	65
Services provided by a hospital: Outpatient	<p>In-network: 15% of our allowance*</p> <p>Out-of-network: 30% of our allowance* and any difference between our allowance and the billed amount</p>	66
Emergency benefits: Accidental Injury	Nothing for initial emergency room visit; or initial urgent care visit; or first physician office visit	71

High Option Benefits	You pay	Page
Emergency Room Benefits: Medical emergency	In-network: \$200 copayment Out-of-network: \$200 copayment and any difference between our allowance and the billed amount	xxx
Mental health and substance use treatment: Applied Behavioral Analysis (ABA)	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	73
Mental Health and Substance Abuse treatment: Inpatient	In-network: \$200 copayment per admission Out-of-network: 30% of the Plan allowance	75
Mental health and substance use treatment: 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 Charges: --30% of the Plan allowance* and any difference between our allowance and the billed amount	76
Prescription drugs: Network and Non-Network Retail pharmacy	30% of cost**	81
Prescription drugs: 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 Generic drugs \$70 for a 30 day supply/\$100 for a 90 day supply; Tier V--Specialty Preferred drugs \$90 for a 30 day supply/\$125 for a 90 day supply; Tier VI--Specialty Non-Preferred drugs \$120 for a 30 day supply/\$250 for a 90 day supply	81
Dental care:	Any difference between our scheduled allowance and the billed amount	85

High Option Benefits	You pay	Page
<p>Wellness and Other Special features:</p>	<p>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; Care Management Program; Livongo, a remote diabetes monitoring program; Lab Savings program; Smoking cessation program; Institutes of Excellence (IOE); Gene-Based, Cellular and Other Innovative Therapies (GCIT™) Designated Network; Genetic testing for prescription drugs; Pharmacy Advisor Program; Wellness Incentive program; Health Risk Assessment; Telephonic Health Coaching program; Telehealth program</p>	<p>88</p>
<p>Protection against catastrophic costs (out-of-pocket maximum):</p>	<p>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.</p> <p>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.</p> <p>Note: Benefit maximums apply and some costs do not count toward this protection</p>	<p>26</p>

Notes

Notes

2024 Rate Information for Rural Carrier Benefit Plan

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

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

Premiums for Tribal employees are shown under the Monthly Premium rate 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	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Nationwide					
High Option Self Only	381	\$271.43	\$130.99	\$588.10	\$283.81
High Option Self Plus One	383	\$586.50	\$251.57	\$1,270.75	\$545.07
High Option Self and Family	382	\$646.18	\$234.11	\$1,400.06	\$507.24