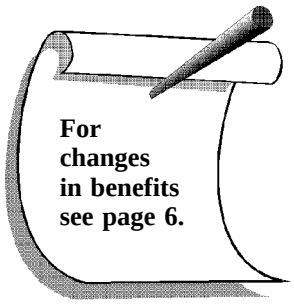
Rural Carrier Benefit Plan

http://www.NRLCA.org

2002

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



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

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

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

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

Enrollment codes for this Plan:
381 High Option - Self Only
382 High Option - Self and Family

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Mutual of Omaha Insurance Company, the underwriter for the **Rural Carrier Benefit Plan** has received accreditation from URAC (also known as the American Accreditation Healthcare Commission), for Health Utilization Management Standards. See the 2002 Guide for more information on accreditation.

Authorized for distribution by the:

United States
Office of Personnel Management
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http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

RI 72-005

Table of Contents

Introduction

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

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

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

Inspector General Advisory

Stop health care fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800/638-8432 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud

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

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

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

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

We also have Preferred Provider Organizations (PPO):

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

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

How we pay providers

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

Your Rights

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

- Years in existence
- Profit status

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

Section 2. How we change for 2002

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

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)
- The following four states have been added to the list of medically underserved states for 2002: Georgia, Montana, North Dakota and Texas. Louisiana has been removed from the list of medically underserved states for 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 18.4% for Self Only or 17.1% for Self and Family.
- We clarified the brochure to better explain that the non-PPO benefits are the standard benefits of this Plan, that PPO benefits apply only when you use a PPO provider, and that when no PPO provider is available, non-PPO benefits apply.
- We no longer limit total blood cholesterol tests to certain age groups (Section 5(a)).
- We now cover certain intestinal transplants (Section 5(b)).
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech (Section 5(a)).
- We clarified the Family planning and Infertility benefits by providing more examples of covered and not covered benefits (Section 5(a)).
- We clarified Surgical procedures to show that we cover a comprehensive range of services, such as operative procedures (Section 5(b)).
- We increased the Plan's calendar year deductible from $250 per person ($500 per family) to $350 per person ($700 per family).
- We changed the deductible for a stay in a non-PPO hospital from $200 for the first admission each calendar year to $200 for each hospital admission.
- We increased the out-of-pocket (catastrophic protection) limits for the Plan from $2,000 per person, $2,500 per family for PPO services to $2,500 per person, $3,000 per family. For non-PPO services, we increased the limits from $2,500 per person, $3,000 per family to $3,000 per person, $3,500 per family.
- We now provide benefits for one routine mammogram each calendar year for women beginning at age 35.
- We now pay for up to 90 visits each calendar year for speech therapy, physical therapy and occupational therapy combined.
- We changed what you pay for physical therapy provided by a PPO physician in his/her office from $15 per visit to 15% of the Plan allowance after the calendar year deductible ($350).
- We removed the five-day limit for initial and follow-up care under our Accidental injury benefit.
- We changed our Accidental dental injury benefit. We removed the time limits for care as long as you remain covered by the Plan. We now pay for care that you receive for an accidental dental injury just like any other illness at the same coinsurance levels with no deductible.
- We changed our smoking cessation benefit to pay for office visits and prescription drugs the same as for any other illness. There is no limit on the number of office visits or the cost of prescription drugs for smoking cessation.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800/638-8432.

Where you get covered care

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

- **Covered providers**

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

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

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

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

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

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

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

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

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

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

Medically underserved areas. Note: We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2002, the states are: Alabama, Georgia, Idaho, Kentucky, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, and Wyoming.

- **Covered facilities**

Covered facilities include:

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

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

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

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

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

What you must do to get covered care

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

Transitional care:

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

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan, or

- lose access to your PPO specialist because we terminate our contract with your specialist for other than cause

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

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

Hospital care:

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

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

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

These provisions apply only to the benefits of the hospitalized person.

How to Get Approval for…

• Your hospital stay

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

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

Warning:

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

How to precertify an admission:

- You, your representative, your physician, or your hospital must call us at 1-800/228-0286 at least seven days before admission.
- If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - — Enrollee's name and Plan identification number;
  - — Patient's name, birth date, and phone number;
  - — Reason for hospitalization, proposed treatment, or surgery;
  - — Name and phone number of admitting physician;
  - — Name of hospital or facility; and
  - — Number of planned days of the hospital stay.

- We will then tell your physician and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your physician, and the hospital.

Maternity care

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

If your hospital stay needs to be extended:

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

What happens when you do not follow the precertification rules

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:
  - — for the part of the admission that was medically necessary, we will pay inpatient benefits, but
  - — for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.
- If no one contacted us, we will decide whether the hospital stay was medically necessary.
  - — If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.
  - — If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.
- If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

Exceptions:

You do not need precertification in these cases:

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

- **Other services**

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

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

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: When you see your PPO physician you pay a copayment of $15 per visit and when you go in the hospital, you pay $200 per admission.

- **Deductible**

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

- The calendar year deductible is $350 per person under High Option. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $700 under High Option.
- We also have separate deductibles for: hospital stays—$200 per admission; dental care—$50 per person each calendar year.

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

- **Coinsurance**

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

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

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

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

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

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

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

- **PPO providers** agree to limit what they will bill you. Because of that, when you use a preferred provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just — 10% of our $100 allowance ($10). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his bill.

- **Non-PPO providers,** on the other hand, have no agreement to limit what they will bill you. When you use a non-PPO provider, you will pay your deductible and coinsurance — plus any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 25% of our $100 allowance ($25). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the $50 difference between our allowance and his bill.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician. The table uses our example of a service for which the physician charges $150 and our allowance is $100. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	PPO physician	Non-PPO physician
Physician's charge	$150	$150
Our allowance	We set it at: 100	We set it at: 100
We pay	85% of our allowance: 85	75% of our allowance: 75
You owe: Coinsurance	10% of our allowance: 15	25% of our allowance: 25
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	$15	$75

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

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

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

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

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

When government facilities bill us

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

If we overpay you

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

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

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

If you…

- are age 65 or over, and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant or as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount — the "equivalent Medicare amount" — set by Medicare's rules for what Medicare would pay, not on the actual charge;
- you are responsible for your applicable deductibles, coinsurance, or copayments you owe under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the Medicare equivalent amount.

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

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

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

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

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

When you have the Original Medicare Plan (Part A, Part B, or both)

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

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

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

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

When you have a Medicare Private Contract with a physician

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

Please see Section 9, Coordinating benefits with other coverage, for more information

Section 5. Benefits — OVERVIEW

(See page 6 for how our benefits changed this year and pages 61-62 for a benefits summary.)

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

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
Professional services of physicians (not including surgery) • In a physician's office • In an urgent care center • Office medical consultations • Second surgical opinion • One routine physical exam per person each calendar year Note: We pay for surgery services by a physician under Surgical services Section 5(b).	PPO: $15 copayment (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians (not including surgery) • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • At home Note: We pay for surgery services by a physician under Surgical services Section 5(b).	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG Note: We consider lab, x-ray and other diagnostic tests you receive in a physician's office during an office visit under **Diagnostic and treatment services** on page 16.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges.
Preventive care, adult	
Routine screenings, limited to: • Sigmoidoscopy, screening - every five years starting at age 50 • Annual coverage of one fecal occult blood test for members age 40 and older. • Prostate Specific Antigen (PSA test) - one annually for men age 40 and older. • Chlamydial infection • One routine pap test per calendar year • Routine mammogram - one annually for women age 35 and older	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Adult immunizations*	*All charges.*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics for dependent children under age 22. Note: Associated charged for office visits and other services are considered under **Diagnostic and treatment services** on page 16.	PPO: Nothing (No deductible) Non-PPO: Nothing up to Plan allowance then any difference between our allowance and the billed amount (No deductible)

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Delivery Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you, your representative, your physician or your hospital must precertify. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Note: If your child is not covered under a Self and Family enrollment, you pay all of your child's charges after your discharge from the hospital.
Not covered: • *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.* • *Services, drugs and supplies related to treatment of impotency.*	*All charges.*
Family planning	
A broad range of voluntary family planning services, including: • Voluntary sterilization • Surgical implant of contraceptive drugs (such as Norplant) • Injection of contraceptive drugs (such as Depo provera) • Fitting, inserting or removing intrauterine devices (such as diaphragms or IUDs) Note: We cover contraceptive drugs and devices under Prescription drug benefits, Section 5(f).	PPO: $15 copayment for non-surgical services. Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount for non-surgical services Note: We cover surgical procedures under **Surgical services** in Section 5(b).
Not Covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, except as shown in *Not covered* below. • Initial diagnostic tests and procedures done only to identify the cause of infertility. • Fertility drugs, hormone therapy and related services • Medical or surgical procedures done to create or enhance fertility Note: The Plan will pay up to $5,000 per person per lifetime for covered infertility services, including prescription drugs.	PPO: 15% of the Plan allowance up to $5,000 then all charges Non-PPO: 25% of the Plan allowance up to $5,000 and any difference between our allowance and the billed amount
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* *— artificial insemination* *— in vitro fertilization* *— embryo transfer and GIFT* *— intravaginal insemination (IVI)* *— intracervical insemination (ICI)* *— intrauterine insemination (IUI)* • *Services and supplies related to ART procedures.* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*
Allergy care	
Testing and treatment, including materials (such as allergy serum)	PPO: 15% of the Plan allowance, if not done along with an office visit Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Note: The allergy services are included in the office visit copayment if performed during an office visit with a PPO provider
Allergy injection	PPO: $15 copayment each (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *RAST tests* • *Food tests* • *End point titration techniques* • *Sublingual allergy desensitization*	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on pages 26 and 27. Note: The Plan pays for services, supplies and tests rendered for the direct treatment of cancer under **Special Features**, Section 5(g) • Dialysis - Hemodialysis and peritoneal dialysis Note: The Plan pays for services, supplies, and testing for kidney (renal) dialysis under Special Features, Section 5(g). • Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Respiratory and inhalation therapies • Growth Hormone Therapy (GHT) Note: Growth hormone is covered under **Prescription drug benefits** in Section 5(f).	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Physical, occupational and speech therapies	
Physical therapy, speech therapy and occupational therapy • 90 total combined visits per calendar year for all three listed therapies provided by: — qualified physical therapists; — qualified physicians; — speech therapists; and — occupational therapists. Note: We only cover physical, speech and occupational therapy when a physician: 1) orders the care; 2) identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 3) indicates the length of time the services are needed.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Note: If your physician provides physical and/or occupational therapy in his/her office, the coinsurance above will apply for those services.
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	
Testing only when necessary because of accidental injury or illness	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Hearing testing when hearing loss is not caused by an accidental injury or illness* • *Hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
• One pair of eyeglasses or contact lenses to correct a change in sight caused directly by an accidental eye injury or intraocular surgery (such as for cataracts), within one year of the injury or surgery Note: See Special Features, Section 5 (g), for our benefit for routine eye examinations.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Refractive eye surgery and related services*	*All charges.*
Foot care	
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Treatment or removal of corns and calluses, or trimming of toenails* • *Orthopedic shoes, orthotics, and other devices to support the feet*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Corsets, trusses* • *Elastic stockings, TED hose and Jobst stockings, unless we determine that they are medically necessary*	*All charges.*

Durable medical equipment (DME)	You pay
Durable medical equipment (DME) is equipment and supplies that: • Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); • Are medically necessary; • Are primarily and customarily used only for a medical purpose; • Are generally useful only to a person with an illness or injury; • Are designed for prolonged use; and • Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Wheelchairs; • Crutches; and • Walkers. Also included are: • Take-home items from the hospital; and • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Home health services	
If home health services are precertified, 90 visits per calendar year up to a maximum plan payment of $80 per visit when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • A qualified physical therapist provides services in the home • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed.	PPO: (No deductible); all charges after we pay $80 per visit Non-PPO: (No deductible); all charges after we pay $80 per visit
If home health services are not precertified, 40 visits per calendar year up to a maximum plan payment of $40 per visit.	PPO: (No deductible); all charges after we pay $40 per visit Non-PPO: (No deductible); all charges after we pay $40 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Custodial care as defined by the Plan*	*All charges.*

Chiropractic	You pay
• Manipulation of the spine and extremities • Related procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	
The Plan has no benefit for this type of care. Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 7.	All charges.
Not covered: • *Naturopathic services* • *Acupuncture*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation (a) office visits—no limit	PPO: $15 copayment (No deductible) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount.
(b) Prescription drugs covered under prescription drug benefit (see **Prescription drug benefits** Section 5(f))	25% of the Plan allowance
(c) Individual or group counseling, up to $100 for one program every 12 months. Over-the-counter (OTC) drugs for smoking cessation are part of the individual/group counseling $100 maximum per program.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount
• Education and management programs for: • Diabetes • Asthma, including pediatric asthma • Osteoarthritis • Congestive heart failure (CHF) Note: The diabetes, asthma and arthritis education programs are provided through Caremark, our prescription benefit management company. For information on the education programs for diabetes, asthma and arthritis call toll-free 1-800/227-3728. The congestive heart failure education program is provided through Healthy *directions*. For information on the education program for congestive heart failure, call toll-free 1-800/228-0286.	PPO: Nothing Non-PPO: Nothing

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section. We added ("No deductible") to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say ("No deductible") when it does not apply.	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures, including delivery of a newborn and circumcision • Treatment of fractures, including casting • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See Section 5(a) - Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons — we cover up to 20% of our allowance for the surgeon's charge	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Surgical procedures — *continued on next page*

Surgical procedures *(continued)*	**You pay**
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: — PPO: 90% of the Plan allowance or — Non-PPO: 85% of the reasonable and customary charge • For the secondary procedure(s): — PPO: 90% of one-half of the Plan allowance or — Non-PPO: 85% of one-half of the reasonable and customary charge Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s). (No deductible) Non-PPO: 15% of the Plan allowance for the primary procedure and 15% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount. (No deductible)
Not covered: • *Reversal of voluntary surgical sterilization.* • *All refractive eye surgeries and similar services.* • *Dental appliances, study models, splints, and other devices or service related to the treatment of TMJ dysfunction.* • *Treatment or removal of corns and calluses, or trimming of toenails.* • *Mutually exclusive procedures— surgical procedures that are not generally performed on one patient on the same day.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: — the condition produced a major effect on the member's appearance and — the condition can reasonably be expected to be corrected by the surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: — surgery to produce a symmetrical appearance on the other breast; — treatment of any physical complications, such as lymphedemas; — breast prostheses; and surgical bras and replacements (see Prosthetic devices, Section 5(a) for coverage) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Cosmetic surgery - any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury and reconstruction of a breast following mastectomy* • *Surgeries related to sex transformation or sexual dysfunction*	*All charges.*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of pathological tori, tumors, and premalignant and malignant lesions • Dental surgical biopsy • Excision of cysts and incision of abscesses when done as independent procedures • Surgical correction of temporomandibular joint (TMJ) dysfunction • Extraction of impacted (unerupted) teeth • Frenectomy and frenotomy not as a result of orthodontic care • Pre- and post-operative medical examinations Note: For extraction of impacted (unerupted) teeth, anesthesia is a covered benefit, but any pre or post-operative medical exams are **not** covered.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single — only for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, or emphysema • Double lung — only for patients with cystic fibrosis • Pancreas (when condition is not treatable by insulin use) • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas for irreversible intestinal failure Bone marrow transplants and stem cell support for: • Allogeneic bone marrow transplants • Autologous bone marrow transplants (autologous stem cell support)	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Organ/tissue transplants — *continued on next page*

Organ/tissue transplants *(continued)*	**You pay**
Autologous peripheral stem cell support for: • Acute lymphocytic or non-lymphocytic leukemia • Advanced Hodgkin's lymphoma • Advanced non-Hodgkin's lymphoma • Advanced neuroblastoma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Epithelial ovarian cancer • Breast cancer • Multiple myeloma Note: We cover related medical and hospital expenses of the donor when we cover the recipient. Note: Mutual of Omaha has special arrangements with 15 transplant facilities to provide services for tissue and organ transplants—its Medical Specialty Network. The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. For a list of facilities included in the Medical Specialty Network, call Customer Service at 1-800/638-8432, consult a provider directory, or visit Mutual of Omaha's website at www.mutualofomaha.com	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered above*	*All charges.*
Anesthesia	
Professional services provided in: • Hospital (inpatient)	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.
Professional services provided in: • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	PPO: 15% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) Note: If your PPO provider uses a non-PPO anesthesiologist, we will pay non-PPO benefits for any anesthesia charges.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Unlike Sections 5(a) and 5(b), in this Section 5(c) the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". The calendar year deductible is: $350 per person ($700 per family)
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Sections 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
NOTE: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
Inpatient hospital	
Room and board, such as • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. NOTE: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area. NOTE: When the non-PPO hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.	PPO: Nothing Non-PPO: $200 per admission Note: If you use a PPO provider and a PPO facility, we may still pay non-PPO benefits if you receive treatment from a radiologist, pathologist, or anesthesiologist who is not a PPO provider.

Inpatient hospital — *continued on next page*

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services Note: Take-home medical supplies, equipment, orthopedic and prosthetic devices are covered under Section 5(a) Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the anesthesiologist bills, we pay Anesthesia benefits. If preadmission testing is performed in the hospital as inpatient then we pay pre-admission tests at the same coinsurance rate as inpatient miscellaneous charges.	PPO: Nothing Non-PPO: 20% of charges
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care (see definition) even when in a hospital* • *Non-covered facilities, such as nursing homes, rest homes, convalescent homes, facilities for the aged, and schools* • *Personal comfort items, such as telephone, television, radio, newspapers, air conditioner, beauty and barber services, guest meals and beds* • *Private nursing care during a hospital stay*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines (not take home drugs) • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures. Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the physician bills for surgery, we pay Surgery benefits.	PPO: Nothing (no deductible) Non-PPO: Nothing (No deductible) up to our allowance, then all charges.

Extended care benefits/Skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): If the stay is precertified, we pay 100% of the reasonable and customary charges for the initial 60 days confinement in a calendar year, when the services are medically necessary. If the stay is not precertified, we pay 80% of the reasonable and customary charges for the initial 30 days confinement in a calendar year, when the services are medically necessary.	PPO: Nothing Non-PPO: Nothing PPO: 20% for the first 30 days then all charges Non-PPO: 20% for the first 30 days, then all charges.
Not covered: • *Custodial care*	*All charges.*
Hospice care	
Hospice is a coordinated program of maintenance and supportive care for the terminally ill prescribed by a physician and provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. • We pay up to $7,500 per lifetime for inpatient and outpatient services, if the care is precertified. • We pay up to $5,500 per lifetime for inpatient and outpatient services, if the care is not precertified.	Nothing up to $7,500, if care is precertified. Then all charges over $7,500. Nothing up to $5,500, if care is not precertified. Then all charges over $5,500.
Not covered: • *Independent nursing* • *Homemaker services*	*All charges.*
Ambulance	
• Professional ambulance service to the nearest hospital equipped to handle the patient's condition	PPO: 15% of the Plan allowance (Calendar year deductible applies) Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount (Calendar year deductible applies)
Not covered: • *Ambulance transportation from the hospital to home*	*All charges.*

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible is: $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is an accidental injury?

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

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say ("No deductible") when it does not apply.	
Accidental injury	
If you or a family member is accidentally injured, the Plan will pay 100% of reasonable and customary charges up to the maximum benefit of $400 for: • Surgery and medical care by a physician • Hospital room and board and other related services and supplies • Private duty nursing services in your home by a registered nurse (R.N.) • X-ray and laboratory tests • Drugs and medicines • Casts, splints, braces, and crutches • Surgical dressings Note: Charges exceeding the maximum benefit ($400) will be considered under Sections 5(a) or 5(b). We pay Hospital benefits if you are admitted to the hospital from the emergency room. See page 41 for accidental dental injuries.	PPO: Nothing (No deductible) The Plan will pay up to $400. Non-PPO: Nothing (No deductible). The Plan will pay up to $400.
Ambulance	
Professional ambulance service to the nearest hospital equipped to handle the patient's condition, including air ambulance when medically necessary Note: See Section 5(c) for non-emergency service.	PPO: 15% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount

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

IMPORTANT

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible or, for facility care, the inpatient deductible apply to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network (Non-PPO) benefits begin on page 35.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say ("No deductible") when it does not apply.	
In-Network benefits	
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. We will reduce your benefits if you do not precertify, preauthorize, get review of continuing treatment, or follow our approved treatment plan for all levels of care.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers	15% of Plan allowance (No deductible for outpatient physician visits)
• Medication management	$15 copayment (No deductible)
• Diagnostic tests	15% of Plan allowance

In-Network benefits — *continued on next page*

In-Network benefits *(continued)*	**You pay**
• Services provided in a hospital or other facility as an inpatient	Nothing (No deductible)
• Services in approved alternative care settings such as: • Partial hospitalization includes a time-limited, ambulatory, active treatment program that: — Offers intensive clinical services that are coordinated and structured in stable surroundings; and — Provides at least 20 hours of scheduled programs in a licensed or accredited facility over at least five days per week • Intensive outpatient programs offer time-limited programs that: — Are coordinated, structured and intensively therapeutic; — Are designed to treat a variety of people with moderate to severe problems with at least one area of daily life because of a mental health or substance abuse condition; and — Provide 3-4 hours of active treatment each day for at least 2-3 days a week	15% of Plan allowance
Not covered: • *Services we have not approved* • *All charges (including room and board) for chemical aversion therapy, conditioned reflex treatments, narcotherapy, and similar aversion treatments* • *Biofeedback and milieu therapy* • *Counseling or therapy for educational or behavioral problems* • *Counseling or therapy for mental retardation or a learning disability* • *Counseling services for marital or family problems* Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	*All charges.*

In-Network benefits *(continued)*	
Preauthorization	To be eligible to receive these enhanced mental health and substance abuse benefits you must obtain a treatment plan and follow all of the authorization processes. These include: • Precertification to establish the medical necessity of your stay in a hospital or other facility. Please see pages 9 and 10 for information on how to precertify your care. If you do not precertify your stay, we will reduce our benefits by $500. • Preauthorization to establish the medical necessity for all levels of outpatient or office care by your physician or other covered provider. Please see pages 9 and 10 for information on how to preauthorize your care. If you do not preauthorize your care within two business days of the first visit, we will reduce any available benefits by 50%. • Review of continuing treatment to establish the medical necessity of your continuing treatment for all levels of outpatient or office care. Please see pages 9 and 10, for information on how to get review of continuing treatment. If you do not get your continuing treatment reviewed or you do not follow your treatment plan, we will reduce any available benefits by 50%.
Network deductibles and out-of-pocket maximums	A $350 per person ($700 per family) calendar year deductible applies to outpatient charges and inpatient and outpatient professional charges. We waive the calendar year deductible for office visits with PPO physicians. Once you reach the combined out-of-pocket maximum (see page 12), the Plan will pay 100% of its allowance for the rest of the calendar year.
Network limitation	If you do not obtain an approved treatment plan, we will provide only Out-of-Network benefits.
How to submit Network claims	Follow the normal claim procedure on page 45.

Out-of-Network benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- See pages 2-34 for In-Network (PPO) benefits.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say ("No deductible") when it does not apply.	
Out-of-Network inpatient mental health benefits	
We pay 100% of room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets.	$200 per hospital admission
We pay 80% of other hospital services and supplies, such as: • Prescribed drugs and medicines • Diagnostic laboratory tests • Medical supplies and equipment	20% of charges
Services in Alternative Care Settings	

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

Inpatient/Outpatient Mental Health/Substance Abuse Treatment Sessions	You pay
We pay for mental health/substance abuse treatment sessions (including group sessions) up to a maximum of $75 per session. This benefit also applies to treatment sessions billed by a hospital or provided by the hospital staff. Note: We pay for medication management and diagnostic testing in Section 5(a).	All charges in excess of $75 (No deductible)
Out of Network substance abuse benefits	
We will pay up to a maximum of $5,500 for inpatient treatment in an in an accredited facility or for an outpatient treatment program. Note: This benefit is limited to two inpatient treatment programs per person per lifetime.	Nothing up to $5,500, then all charges
Not covered out-of-network: • *Services we have not approved* • *All charges (including room and board) for chemical aversion therapy, conditioned reflex treatments, narcotherapy, and similar aversion treatments* • *Biofeedback and milieu therapy* • *Counseling or therapy for educational or behavioral problems* • *Counseling or therapy for mental retardation or a learning disability* • *Counseling services for marital or family problems*	*All charges.*

Precertification	Follow the normal procedure on pages 9 and 10 to get approval for your hospital stay, partial hospitalization, or intensive outpatient program.
Out-of-Network out-of-pocket maximum	For those benefits where coinsurance applies, we pay 100% of the Plan allowance for the rest of the calendar year after your expenses (including the deductible) total to $8,000 per person during a calendar year.
How to submit Out-of-Network claims	Follow the normal claim procedure on page 45.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $350 per person ($700 per family). The calendar year deductible applies to almost all benefits in this Section. We added ("No deductible") to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain your prescription.** You may fill your prescription at a Caremark network pharmacy, a non-network pharmacy, or through the Caremark mail order prescription program.
  - **Caremark network pharmacy**
    You may fill your prescription at a Caremark network pharmacy. To find a participating pharmacy where you live, call Caremark toll-free at 1-800/831-4440 or on the Internet at www.rxrequest.com or as a link through our web page at www.nrlca.org. **You must show the pharmacy your Plan ID card (that includes the Caremark logo) or a Caremark prescription drug card to receive the negotiated discount price.** You pay the full discounted price for your prescription and then file a claim with us. **Prescriptions you purchase at a Caremark network pharmacy without using your ID card or a Caremark drug card are at the full regular price charged by the pharmacy.**
  - **Non-Network Pharmacy**
    You may fill your prescription at any non-network pharmacy. You pay the full regular price for your prescription and then file a claim with us.
  - **Caremark mail order prescription program**
    You may fill your long-term prescription through the Caremark mail order prescription program. You will receive order forms and information on how to use the mail order prescription program with your Plan ID card. To order your prescription by mail: 1) complete the Caremark order form; 2) enclose your prescription(s) and copayment(s); 3) mail your order to Caremark, P O Box 659572, San Antonio, TX 78256-9572; and 4) allow approximately two weeks for delivery. You will receive order forms for refills and future prescription orders each time you use the mail order program. You can also order refills from the mail order program by telephone toll-free at 1-800/213-0879 or on the Internet at www.rxrequest.com.
- **These are the dispensing limitations.**
  - You may purchase up to a 34-day supply of medication at a Caremark network pharmacy. There is no limit on the number of refills that you can buy at a Caremark network pharmacy.
  - There is no day supply or refill limit for medications that you buy at a non-network pharmacy.
  - A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name.
  - You may purchase up to a 90-day supply of a medication through the Caremark mail order prescription program. If you request a refill before you use 75% of the medication (based on your physician's written directions for taking the medication), Caremark will return the refill request to you. Caremark follows generally accepted pharmacy standards when filling your prescriptions. These include Federal and state

Prescription drug benefits — *continued on next page*

pharmacy regulations, the professional judgment of the pharmacist, and the usage recommendations of the drug manufacturer as approved by the U.S. Food and Drug Administration (FDA). If a Federally approved generic drug is available, Caremark will substitute for a brand name drug unless your physician specifies that it is medically necessary that you receive the brand name drug. Certain types of prescription medications are not available through the mail order program such as:

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

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.

- We have an open formulary for our mail order prescription program. If your physician believes a brand name drug is necessary or there is no generic available, your physician may prescribe a brand name drug from a formulary list. This list of brand name drugs is a preferred (not required) list of drugs that we selected to meet patient needs. To request a prescription drug formulary list, call Caremark toll-free at 1-800/831-4440.
- If you have Medicare Part B, we do not waive your deductible or coinsurance for prescription drugs and supplies that you buy at a Caremark network pharmacy or at a non-network pharmacy. However, your copyment is reduced for prescriptions that you order through the Caremark mail order prescription program.

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

- **When you have to file a claim.** Follow the normal claim procedure on page 45. There is no special claim form to fill out for your prescription drug expenses.

Prescription drug benefits begin on next page

Section 5 (f). Prescription drug benefits *(continued)*

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "No deductible" when it does not apply.	
Covered medications and supplies	
When you enroll in the Plan, you will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a pre-addressed reply envelope for the mail-order prescription program. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs and medicines (including those prescribed during a non-covered hospital stay or in a non-covered facility) that require a physician's prescription by Federal law of the United States except those listed as *Not covered* below. • Insulin • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices	• Network Retail: 25% of cost • Network Retail with Medicare Part B: 25% of cost • Non-Network Retail: 25% of cost • Non-Network Retail with Medicare Part B: 25% of cost • Network Mail Order: $13 generic/$18 brand name (No deductible) • Network Mail Order with Medicare Part B: $3 generic/$6 brand name (No deductible) Note: If there is no generic equivalent drug available, you will still have to pay the brand name copayment.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs to treat impotence and sexual dysfunction* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription (over-the-counter) medicines*	*All charges.*

Section 5 (g). Special features

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

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The dental deductible is: $50 per person. The dental deductible applies to almost all benefits in this Section. We added ("No deductible") to show when the dental deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage.

Note: We cover a hospital stay for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We cover the dental procedure under Dental benefits listed below.

IMPORTANT

Accidental injury benefit	You pay
The Plan will pay reasonable and customary charges for the treatment or repair (including root canal therapy and crowns) of an accidental injury to sound natural teeth (not from biting or chewing), provided the accident occurs while covered by the FEHB Program, and the treatment or repair is completed while covered by the Plan. Note: We may request dental records, including x-rays, to verify the condition of your teeth before the accidental injury. Charges covered for dental accidents cannot be considered under Dental Benefits.	PPO: 10% of the Plan allowance (No deductible) Non-PPO: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Dental benefits Class A Schedule

Service	We pay (scheduled allowance)	You pay
The plan pays actual charges for up to two visits per person per calendar year up to the scheduled Plan allowance (No deductible)		All charges that exceed the Plan's scheduled allowance for the service
Oral exam	$12.50	
Prophylaxis, adult	$22.00	
Prophylaxis, child (thru age 14) • with fluoride treatment	$15.00 $24.00	
Space maintainer	$88.00	
Complete X-ray series	$34.00	
Panoramic X-ray	$34.00	
Single film X-ray	$ 5.50	
Each additional X-ray film (up to 7)	$ 4.00	
Bitewings - 2 films	$ 9.00	
Bitewings - 4 films	$14.00	

Dental benefits — *continued on next page*

Dental benefits Class B Schedule

Service	We pay (scheduled allowance)	You pay
After a deductible of $50 per person during the calendar year, the Plan pays actual charges up to the scheduled allowance for each service. There is no annual limit on the amount of services you receive.		All charges that exceed the Plan's allowance for the service.
Restorations		
1 surface deciduous	$ 12.50	
2 surface deciduous	$ 18.50	
3 surface deciduous	$ 23.50	
1 surface permanent	$ 14.00	
2 surface permanent	$ 20.50	
3 or more surface permanent	$ 26.50	
Gold restoration	$103.50	
Extractions		
Single tooth	$ 16.00	
Each additional tooth	$ 15.00	
Pulp capping-direct	$ 9.50	
Pulpotomy-vital	$ 21.00	
Root canal therapy		
This includes the actual root canal treatment and ay retreatments		
One root	$106.00	
Two roots	$126.00	
Three or more roots	$170.00	
Periodontics		
Gingival curettage (per quadrant)	$ 26.50	
Crowns/abutments		
Resin and Resin with metal	$120.00	
Porcelain	$113.50	
Porcelain with gold	$120.00	
Gold (full cast and 3/4 cast)	$120.00	
Prefabricated resin and stainless steel	$ 21.50	
Pontics		
Porcelain and Porcelain with gold	$120.00	
Dentures		
Complete upper or lower	$126.00	
Partial without bar	$138.00	
Partial with bar	$157.00	
Repairs (dentures and partials)	$ 14.00	
Denture relining	$ 40.50	

When this schedule lists a type of dental care, but does not list a particular dental procedure under that type of care, we will determine the maximum allowance for that procedure.

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

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

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

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

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

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

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

Please consult the separate descriptive pamphlet for detailed information.

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

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

Vision and Hearing Insurance—The NRLCA Vision and Hearing Plan is available to all members of the NRLCA. There are two levels of coverage: Standard and Superior. Please see the separate pamphlet for complete information.

- Provides discounts on frames, lenses, and contact lenses at participating providers
- Provides discounts on laser eye surgery at TLC Vision Centers and See Clearly Vision Centers
- Provides discounts on hearing aids at Beltone Hearing Centers, free hearing exam and an extended warranty on the hearing aid.

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

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

Benefits on this page are not part of the FEHB contract

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

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

We do not cover the following:

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

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

Section 7. Filing a claim for covered services

How to claim benefits

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

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

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

Rural Carrier Benefit Plan
P. O. Box 668329
Charlotte, NC 28266-8329

Bills and receipts should be itemized and show:

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

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

In addition:

- You must send a copy of the explanation of benefits (EOB) from any primary payer (such as the Medicare Summary Notice (MSN)) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.

Claims for prescription drugs and supplies that are not ordered through the Mail Order Prescription Drug Program must include receipts that have the patient's name, the prescription number, name of drug or supply, prescribing physician's name, date, charge, and pharmacy name. The pharmacist must sign any computer printout or pharmacy ledger.

Records

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

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Deadline for filing your claim

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

Overseas claims

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Rural Carrier Benefit Plan, P.O. Box 668329, Charlotte, NC 28266-8432 and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial — go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3620
	Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call.

Disputed claims process *(continued)*

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

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

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

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 2 at 202/606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

• What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800/633-4227) for more information
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

.

• The Original Medicare Plan (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. Some things are not covered under Original Medicare, like prescription drugs.

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.

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

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

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

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

- Medical services and supplies provided by physicians and other health care professionals. If you are enrolled in Medicare Part B, we will waive our $350 calendar year deductible and pay the $100 Part B deductible for you.

  NOTE: We do not waive the $350 calendar year deductible for prescription drug expenses when the medication is purchased at a pharmacy.

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

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

Primary Payer Chart

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

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan — a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800/633-4227) or at www.medicare.gov.

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

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

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

- **Private Contract with your physician**

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

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us at 1-800/638-8432 for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Acupuncture

The technique of passing long thin needles through the skin into specific external body locations to relieve pain, to produce regional anesthesia, or for other therapeutic purposes.

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.

Copayment

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

Coinsurance

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

Covered services

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

Custodial care

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

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

We determine what treatments or services are custodial care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 11.

Experimental / investigational services

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

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

- reliable evidence shows that it is the subject of on-going phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

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

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

Hospital admission

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

Medical necessity

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

- are appropriate to diagnose or treat the patient's condition, illness or injury;
- are consistent with standards of good medical practice in the United States;
- are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
- are not a part of or associated with the scholastic education or vocational training of the patient; and
- in the case of inpatient care, cannot be provided safely in an outpatient setting.

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

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

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

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

Us/We

Us and we refer to the Rural Carrier Benefit Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you 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. 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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

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

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

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

- **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think their health plan and/or Medicare covers long-term care. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need? Consider buying long term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for care in a nursing home, in an assisted living facility, in your home, adult day care, hospice care, and more. *Long term care insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but you should have a plan just in case. *LTC insurance may be vital to your financial and retirement planning.*

Is long term care expensive?

- Yes. A year in a nursing home can exceed $50,000 and only three 8- hour shifts a week can exceed $20,000 a year, that's before inflation!
- LTC can easily exhaust your savings but LTC insurance can protect it.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look under "*Not covered*" in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, assisted living, or continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received. LTC insurance can provide choices of care and preserve your independence.

When will I get more information?

- Employees will get more information from their agencies during the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

A toll-free telephone number will begin in mid-2002. You can learn more about the program now at www.opm.gov/insure/ltc.

Index

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

Summary of benefits for the Rural Carrier Benefit Plan - 2002

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $350 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You pay	Page
Medical services provided by physicians:	**PPO:** $15/office visit	
• Diagnostic and treatment services provided in the office	**Non-PPO:** 25% of our allowance and any difference between our allowance and the billed amount*	16
• Surgery.....	**PPO:** 10% of our allowance	24-27
	Non-PPO: 15% of our allowance and any difference between our allowance and the billed amount	
Services provided by a hospital:	**PPO:** Nothing	28-30
• Inpatient	**Non-PPO:** $200 deductible per admission; nothing for room and board; 20% of other charges	
• Outpatient	**PPO:** 15% of our allowance*; nothing for a surgical facility	29
	Non-PPO: 25% of our allowance* and any difference between our allowance and the billed amount, any difference between our allowance and the billed amount for a surgical facility	
Emergency benefits:		
• Accidental injury	Up to $400	31
• Medical emergency.....	Regular benefits	16-30

Summary of benefits — *continued on next page*

Benefits	You pay	Page
Mental health and substance abuse treatment	**PPO:** Nothing	32
• Inpatient	**Non-PPO:** $200 deductible per admission; nothing for room and board; 20% of other charges. For substance abuse, charges over $5,500 per treatment program	35
Outpatient	**PPO:** 15% of our allowance* (no deductible on physician visits)	33
	Non-PPO: Charges over $75 per treatment session (no deductible). For substance abuse, charges over $5,500 for an aftercare program (combined with inpatient)	35-36
Prescription drugs	**Network and Non-network Pharmacy:** 25% of the cost* **Mail Order Pharmacy:** $13/generic drug; $18/brand name drug **Mail Order With Medicare Part B:** $3/generic; $6/brand name drug	37-39
Dental Care	Any difference between our scheduled allowance and the billed amount	41-42
Special features: Flexible benefits option; Cancer treatment benefit; Kidney dialysis benefit; 24 hour nurse line, Travel assistance program; Routine eye exam benefit		40
Protection against catastrophic costs (your out-of-pocket maximum)	**PPO:** Nothing after **$2,500**/Person or $3,000/Family per calendar year **Non-PPO:** Nothing after $3,000/Person or $3,500/Family per calendar year. Note: Benefit maximums apply and some costs do not count toward this protection	12

Notes

2002 Rate Information for

Rural Carrier Benefit Plan

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	381	N/A	N/A	$212.03	$130.35	$115.52	$42.50
High Option Self and Family	382	N/A	N/A	$484.06	$213.30	$263.75	$58.11