Rural Carrier Benefit Plan 1999

A Managed Fee-for-Service Plan

Sponsored 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 are permitted to enroll in this Plan. To enroll you must also be, or must 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 contact your State Secretary's office or the National Rural Letter Carriers' Association.

Membership dues: Dues vary in each state.

Enrollment code for this Plan:
381 Self only
382 Self and family

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at **www.nrlca.org**

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 72-005

Rural Carrier Benefit Plan

The National Rural Letter Carriers' Association (NRLCA) (Carrier) has entered into Contract No. CS 1073 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by the Mutual of Omaha Insurance Company which administers this Plan on behalf of the Carrier and is referred to as Carrier in this brochure. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is the official statement of benefits on which you can rely. It describes the benefits, exclusions, limitations, and maximums of the Rural Carrier Benefit Plan for 1999 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 800/638-8432 and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N. W., Room 6400
Washington, D. C. 20415

The inappropriate use of membership identification cards, e.g., to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan**,** is also subject to review by the Inspector General and may result in an adverse administrative action by your agency**.**

When you need help with Plan benefits, or getting your ID card, call your Plan at 800/ 638-8432. The Fraud Hotline cannot help you with these.

Using This Brochure

The **Table of Contents** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers.** It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits,** on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: Other Medical Benefits are paid after you satisfy the calendar year deductible and Additional Benefits are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. That is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid one way if it is billed by an inpatient facility and paid another way when it is billed by a doctor, physical therapist or outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification;** hospital stays must be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare.** And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

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How This Plan Works

Help Contain Costs

You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and flexible benefits option**.**

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with Mutual of Omaha's Care Review Unit before being admitted to the hospital. Be a responsible consumer. Be aware of your Plan's cost containment provisions. Avoid penalties and help keep premiums under control by following the procedures specified on pages 23 and 24 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Carrier has the authority to determine the most effective way to provide services. The Carrier may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. The Carrier may decide to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely the Carrier's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

Facilities and Other Providers

Covered facilities

Birthing center

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

Hospice

A public or private agency or organization that:

1) administers and provides hospice care; and
2) meets one of the following requirements:
   a) licensed or certified as such by the State in which it is located;
   b) certified (or is qualified and could be certified) to participate as such under Medicare;
   c) accredited as such by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); or
   d) meets the standards established by the National Hospice Organization.

Hospital

(1) An institution which is accredited as a hospital under the hospital accreditation program of the JCAHO; or (2) any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with twenty-four-hour-a-day nursing service, and that is primarily engaged in providing: (a) general inpatient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control, or (b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including x-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities. In no event shall the term hospital include a convalescent nursing home or institution or part thereof that (1) is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged; (2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or (3) is operated as a school.

For inpatient treatment of alcohol and drug abuse, the term hospital also includes a free-standing alcohol and drug abuse treatment facility approved by the JCAHO.

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.

Covered providers

A licensed doctor of medicine (M.D.), a licensed doctor of podiatry (D.P.M.), or licensed doctor of osteopathy (D.O.). Other covered providers include a qualified clinical psychologist, clinical social worker, physician assistant, optometrist, dentist, chiropractor, nurse midwife, nurse practitioner/clinical specialist and nursing school administered clinic. For purpose of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

A qualified clinical psychologist includes an individual who has earned either a Doctoral or Masters degree in psychology or an allied discipline and who is licensed or certified in the state where the service is performed. This presumes a licensed individual has demonstrated to the satisfaction of state licensing officials that he/she is qualified to provide psychological services in that state by virtue of academic and clinical experience**.**

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1999, the States designated as medically underserved are: Alabama, Idaho**,** Louisiana, Mississippi, New Mexico, North Dakota**,** South Carolina, South Dakota, and Wyoming.

Cost Sharing

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward a deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of covered expenses an individual must incur for covered services and supplies each calendar year before the Plan pays certain benefits. The deductible is the $250 you pay before the Plan starts paying expenses for Other Medical Benefits.

Cost Sharing *continued*

Hospital

You pay $200 per person for the first hospital admission in a calendar year before the Plan starts paying inpatient room and board benefits.

Dental

You pay a $50 deductible per person each calendar year for all dental procedures included in the Class B Schedule of Dental Allowances. You may count toward the deductible only those expenses covered under the Class B Schedule of Dental Allowances. You cannot count toward the deductible any charges in excess of the amounts listed in the Class B Schedule of Dental Allowances.

Mental conditions

For inpatient treatment of mental conditions you pay the first $400 of covered hospital charges per person each calendar year.

Carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible in the prior year will be covered by your old plan if they are for care you got in January before the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Family limit

There is a separate calendar year deductible of $250 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members (1) after two family members have each met their calendar year deductible, or (2) when the combined covered expenses applied to the deductibles for all family members reach $500 during a calendar year.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The Plan will base this percentage on either the billed charge or the reasonable and customary charge, whichever is less**.** For instance, when a Plan pays 80% of reasonable and customary charges for a covered service, you are responsible for 20% of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges $100 for a service but the Plan's reasonable and customary allowance is $95, the Plan will pay 80% of the allowance ($76). You must pay the 20% coinsurance ($19), plus the difference between the actual charge and the reasonable and customary allowance ($5), for a total member responsibility of $24.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges $100 for a service but routinely waives the 20% coinsurance, the actual charge is $80. The Plan will pay $64 (80% of the actual charge of $80).

When hospital charges are limited by law

When inpatient claims are paid according to a Diagnostic Related Group (DRG) limit (for instance, for admissions of certain retirees who do not have Medicare - see page 8), the Plan will pay 30% of the total covered amount as room and board charges and 70% as other charges and will apply your coinsurance accordingly.

Lifetime maximums

- Inpatient benefits for the treatment of alcoholism and drug abuse are limited to two inpatient programs per person per lifetime.
- The smoking cessation benefit is limited to one per person per lifetime.
- Diagnosis and treatment of infertility is limited to $5,000 per person per lifetime.

General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is the official statement of benefits on which you can rely.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 24,25 and 26 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is 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. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100% of allowable expenses. When this Plan pays secondary, it will only make up the difference between the primary plan's coverage and this Plan's coverage. Thus, the combined payments from both plans may not equal the entire amount billed by the provider.

The determination of which health coverage is "primary" (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation means the Plan's right to recover any payments made to you or your dependent by a third party's insurer, because of an injury or illness caused by a third party. Third party means another person or organization.

If you or your dependent receive Plan benefits and have a right to recover damages from a third party, the Plan is subrogated to this right. All recoveries from a third party (whether by lawsuit, settlement or otherwise) must be used to reimburse the Plan for benefits paid. Any remainder will

be yours or your dependent's. The Plan's share of the recovery will not be reduced because of attorney's fees, or because you or your dependent has not received the full damages claimed, unless the Plan agrees in writing to a reduction.

You must promptly advise the Plan whenever a claim is made against a third party with respect to any loss for which Plan benefits have been or will be paid. You or your dependent must execute any assignments, liens or other documents and provide information as the Plan requests. Plan benefits may be withheld until documents or information is received.

Overpayments

The Carrier will make reasonably diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Limit on your costs if you're age 65 or older and don't have Medicare

The information in these following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by Medicare Part A, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the equivalent Medicare amount. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 800/638-8432 for assistance.

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the Medicare-approved amount (which is the Medicare fee schedule for the service), or the actual charge, whichever is lower. The Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible or coinsurance.

If your physician participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's surgery benefit, the Plan will pay 85% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 15% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance amount, and any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the hospital or physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 800/638-8432 for assistance.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 7); while in active military service; or required for illness or injury sustained 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
- Furnished by immediate relatives or household members, such as spouse, parents, child, brother or sister by blood, marriage, or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction, sexual inadequacy or impotence
- Not specifically listed as covered
- Investigational or experimental
- Received before coverage under the Plan begins or after it ends
- The charges for services and supplies are not reasonable and customary
- Not recommended or approved by a covered provider
- Not provided in accordance with generally accepted professional medical or dental standards in the United States

Benefits will not be paid for:

- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived
- Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Part A and/or B (see page 8), 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
- Acupuncture
- Preventive medical care and services (including periodic checkups and well child care after age 24 months, associated X-ray and lab tests) except as provided under Other Medical Benefits (pages 15 and 16) and Additional Benefits (page 16)
- Weight control or any treatment of obesity except surgery for morbid obesity (ileojejunal, balloon or gastric shunt procedures)
- Programs for smoking cessation and related drugs even if prescribed by a doctor, except as provided under Other Medical Benefits (page 16)
- Inpatient private duty nursing
- Any services rendered related to a learning disability
- Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning
- Breast implants (except as provided on page 15), 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 for on pages 15 and 16)
- Hearing aids and examinations for them
- Eyeglasses and contact lenses (except as covered under Other Medical Benefits on page 15)
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction including dental appliances, study models, splints and other devices
- Services for cosmetic purposes
- Procedures, services, drugs and supplies related to abortion 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 rape or incest

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 23 and 24 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States. For information on when Medicare is primary, see page 25.

Room and board

After you pay the first $200 for your first admission in a calendar year, the Plan will pay **100%** of the semiprivate room and board charges.

For each confinement, the Plan will consider semiprivate or ward accommodations in a hospital to include all nursing care, meals and special diets. The Plan will consider charges for accommodations in intensive care units for each confinement, even though these charges may exceed the hospital's semiprivate room rate.

If a private room is used, the Plan will consider the average semiprivate room rate charged by the hospital or, if the hospital has only private rooms, the average semiprivate rate for hospitals in the same geographic area. However, if the patient's isolation is medically necessary to prevent contagion to others, the private room charge will be considered.

Other charges

The Plan will pay **80%** of other charges for services and supplies furnished by a hospital while you are a bed patient (inpatient) in a hospital. These include, but are not limited to:

- Use of operating room
- Surgical dressings
- Drugs and medicines for use in the hospital
- X-ray and laboratory examinations
- Blood or blood plasma, if not donated or replaced, and its administration

Limited benefits

Pre-admission testing

The Plan pays **100%** of reasonable and customary charges for pre-admission testing received within 7 days of admission as an inpatient to a hospital.

Hospitalization for dental work

The Plan pays Inpatient Hospital Benefits in connection with dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient.

Related benefits

Consultations

Inpatient consultations are covered only under Additional Benefits (see page 16).

Professional charges

Charges for professional services of a doctor, even though billed by a hospital as part of the hospital services, are covered only under Other Medical Benefits (see page 15).

Prosthetic appliances

Prosthetic appliances (e.g., pacemakers, artificial hips, intraocular lenses) provided by a hospital are covered only under Other Medical Benefits (see page 15).

Take-home items

Drugs and medicines and other medical supplies furnished upon discharge for use at home are covered only under Other Medical Benefits (see page 15) or Prescription Drug Benefits (see page 18).

What is not covered

- A hospital admission that is not medically necessary, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a physician's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or the quality of medical care rendered
- Confinement in nursing homes, rest homes, places for the aged, convalescent homes or any place that is not a hospital, skilled nursing facility or hospice (see definitions)
- Custodial care (see definition) even when provided by a hospital
- Inpatient private duty nursing
- Personal comfort items such as radio, television, telephone, air conditioner, beauty and barber services, guest cots, guest meals, newspapers and similar items

Surgical Benefits

What is covered

The Plan pays for the following services:

Hospital inpatient and outpatient

The Plan pays **85%** of reasonable and customary charges for inpatient or outpatient surgery. Charges for normal pre- and post-operative care by the doctor who performs surgery, including inhospital visits for the first 14 days after an operation, are considered to be part of the surgical fee. Hospital visits by the surgeon after 14 days are considered under Other Medical Benefits (see page 15). Charges for use of an outpatient surgical facility are covered as Additional Benefits (see page 17).

Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session by a doctor/surgeon or podiatrist, the Plan pays as follows: the value of the major procedure plus 50 percent of the value of the lesser procedure(s) will be considered.

Incidental procedures

When an incidental procedure (e.g., incidental appendectomy, lysis of adhesions, excision of scar) is performed through the same incision, the reasonable and customary allowance will be that of the major procedure only. Separate benefits will not be provided for procedures deemed by the Plan to be incidental to the total surgery.

Assistant surgeon (inpatient/outpatient)

The Plan pays **85%** of reasonable and customary charges of an assistant surgeon for inpatient or outpatient surgery when determined by the Plan to be medically necessary.

Second opinion (voluntary)

The Plan pays **100%** of reasonable and customary charges for a second, outpatient surgical opinion by an independent consulting doctor other than the surgeon.

Anesthesia

This Plan pays **85%** of the reasonable and customary charges for general anesthesia and its administration.

Organ/tissue transplants and donor expenses

All reasonable and customary charges incurred for a covered surgical transplant whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury.

What is covered

- Cornea, heart, kidney, liver, pancreas (when condition is not treatable by use of insulin therapy), heart/lung, single lung and double lung transplants
- Bone marrow transplants and stem cell support as follows: allogeneic bone marrow transplants; autologous bone marrow transplants (autologous stem cell support) and 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, and multiple myeloma
- Related medical and hospital expenses of the donor when the recipient is covered by the Plan. Recipient means an insured person who undergoes an operation to receive an organ transplant. Donor means a person who undergoes an operation for the purpose of donating an organ for transplant surgery.

What is not covered

- Transplants not listed as covered

Surgical Benefits *continued*

Cosmetic surgery

Cosmetic surgery (see definition) is covered only if necessary for repair of accidental injury sustained while covered by the FEHB Program, to correct congenital anomalies, or for reconstruction of a breast that was removed or partially removed.

Oral and maxillofacial surgery

Oral surgery is covered only for:

- the extraction of impacted (unerupted) teeth
- correction of fractures of the jaw and/or facial bones
- removal of salivary stones
- correction of cleft palate
- correction of severe malocclusion (protruding or retruding mandible or maxilla) caused by disease, injury, or congenital malformation
- excision of bony cysts of the jaw (unrelated to tooth structures)
- excision of pathological tori, tumors, and premalignant and malignant lesions
- surgical correction of temporomandibular joint (TMJ) dysfunction
- dental surgical biopsy
- frenectomy or frenotomy unrelated to orthodontic care

Mastectomy surgery

Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

What is not covered

- Treatment or removal of corns and calluses, or trimming of toenails
- Radial keratotomy or similar surgery done in treating myopia (except for cornea graft)
- Dental appliances, study models, splints and other devices or services related to the treatment of TMJ dysfunction
- Reversal of voluntary surgical sterilization

Maternity Benefits

What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary.

Inpatient hospital

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 23 and 24 for details.

Room and board

After you pay the first $200 for your first hospital admission in a calendar year, the Plan will pay **100%** of the semiprivate room and board charges.

Other charges

The Plan will pay **80%** of other hospital charges.

Bassinet or nursery charges for days on which mother and child are both confined are considered expenses of the mother and not expenses of the child. Doctor's in-hospital charges for routine newborn care and any other charges which are expenses of the child, will be considered only if the child is covered by a family enrollment. Routine circumcision is covered under Surgical Benefits for family enrollments.

Outpatient care

The Plan pays **100%** of the reasonable and customary charges for covered services at the time of delivery when:

- Delivery is on an outpatient basis, or
- Delivery is at a licensed birthing center, or
- Inpatient delivery results in a hospital confinement of one day(overnight) or less

If the mother or newborn child is transferred from a birthing center to a hospital due to medical complications, the birthing center expenses will be paid at **100%** of reasonable and customary charges.

For a confinement of one day (overnight) or less, if the mother and child leave the hospital against medical advice, this benefit is not payable and only the regular Plan benefits will apply.

Obstetrical care

The Plan pays **85%** of reasonable and customary charges for covered expenses due to delivery by a doctor or midwife. Prenatal and postnatal doctor and midwife visits are covered under Other Medical Benefits (page 15).

Related benefits

Diagnosis and treatment of infertility

Services for the diagnosis and treatment of infertility are covered under Other Medical Benefits (see page 15).

Tests

Sonograms, amniocentesis and other related tests on the unborn are covered under Other Medical Benefits (see page 15).

Voluntary sterilization

The Plan pays the same benefits as for any other surgical procedure. See Surgical Benefits (page 11).

For whom

Benefits are payable under Self Only enrollments and for family members under Self and Family enrollments.

What is 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 and supplies related to treatment of impotency
- Reversal of voluntary surgical sterilization
- Contraceptive devices and contraceptive drugs (including oral contraceptives and implanted drugs, such as Norplant)
- Assisted Reproductive Technology (ART) procedures, such as artificial insemination, in vitro fertilization, embryo transfer or placement and GIFT, as well as services and supplies related to ART procedures are not covered

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Mental conditions

Inpatient care

After a $400 deductible for covered hospital charges per person per calendar year, the Plan then pays **100%** of covered hospital charges for the first 31 days and **50%** of such charges after the 31st day.

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 23 and 24 for details.

Partial hospitalization

If you or a covered family member incurs expense for partial hospitalization, the Plan will pay for each day of confinement as follows:

- benefits payable are subject to the same limitations and conditions, including precertification, as for inpatient care
- at least four hours of continuous treatment, but not more than 12 hours, in any consecutive 24 hour period in a hospital
- one day of inpatient care reduces the available number of partial hospitalization days by two; two days of partial hospitalization reduces the available number of inpatient care days by one

Partial hospitalization must be a medically necessary alternative to inpatient hospitalization.

Catastrophic protection benefit

When the 50% you pay for covered hospital charges after the 31st day, plus the deductible, totals $8,000 in a calendar year for one member, the Plan will then pay **100%** of that person's covered hospital charges for the rest of that calendar year.

Inpatient/ outpatient visits

The Plan will consider charges for psychiatric treatment sessions (including group sessions) up to a maximum benefit of $75 per session even when billed by a hospital or provided by the hospital staff. These services are covered only when rendered by a covered provider (see page 5), even when billed for by a hospital or provided by hospital personnel. These services are not subject to a deductible or coinsurance and their cost does not apply to the catastrophic protection benefit for mental conditions. Charges for psychological testing and pharmacological visits are covered under Other Medical Benefits (see page 15). The medical management of mental conditions will be covered under Other Medical Benefits (see page 15). Related drug costs will be covered under the Plan's Prescription Drug Benefits (see page 18).

Substance abuse

The Plan will pay up to $5,500 for an inpatient treatment program in an accredited alcohol or drug abuse treatment facility. The Plan will pay up to $250 for an aftercare outpatient treatment program that immediately follows an inpatient program.

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 23 and 24 for details.

Lifetime maximum

The Substance abuse benefit is limited to two (2) inpatient programs per person per lifetime. No other benefits are payable for this condition.

What is not covered

- All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board)
- Biofeedback and milieu therapy
- Counseling or therapy for educational or behavioral problems, or related to mental retardation or learning disabilities.
- Marital, family or other counseling services

Other Medical Benefits

What is covered

After the $250 deductible has been met, the Plan pays **75%** of reasonable and customary charges for the following:

- Doctors' visits (inhospital, home or office)
- Prenatal and postnatal doctor and midwife visits
- Insulin, including hypodermic syringes
- Physical therapy performed by a registered physical therapist
- Oxygen and equipment for its administration
- Electroshock therapy
- Radiation therapy
- Chemotherapy
- Allergy treatment, including injections and testing
- One pair of eyeglasses or contact lenses, if required as a result of intraocular surgery and obtained within one (1) year of the surgery, but not spare glasses or lenses after surgery
- Hospital outpatient services and supplies
- Speech therapy by a qualified speech therapist when loss of speech is due to illness or injury
- Rabies shots when the individual has been exposed to active rabies
- X-ray and laboratory examinations except for dental work
- Pathological services and machine diagnostic tests
- Orthopedic appliances, including orthopedic braces and crutches
- Prosthetic appliances such as artificial limbs and eyes, including replacement, repair, or adjustment when required because of a change in the patient's physical condition. Also covered are first purchase (not replacement) of one externally fitted breast prosthesis and one fitted bra, and first internal breast prosthesis following mastectomy

Routine services

In addition to coverage of diagnostic X-ray, laboratory and pathological services and machine diagnostic tests, the Plan pays **75%** of reasonable and customary charges for the following routine (screening) services after the $250 deductible has been met.

Physical exam

Annual coverage of one routine physical exam per person, limited to a maximum charge of $200 per person. A routine physical exam is a complete evaluation of a patient without symptoms or illness and includes a comprehensive history and physical examination. Physical exam charges applied to satisfy the deductible are counted toward the benefit limit.

Breast cancer screening

Mammograms are covered for women age 35 and older as follows:

- From age 35 through 39, one mammogram screening during this five year period;
- From age 40 through 49, one mammogram screening every calendar year;
- From age 50 through 64, one mammogram screening every calendar year; and
- At age 65 or over, one mammogram screening every two consecutive calendar years.

Cervical cancer screening

Annual coverage of one pap smear for women age 18 and older

Colorectal cancer screening

Annual coverage of one fecal occult blood test for members age 40 and older

Prostate cancer screening

Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older

Limited benefits

The following benefits are covered at **75%** after the $250 deductible has been met:

Chiropractor

Plan pays up to $300 per person each calendar year for service of a chiropractor. Services of a chiropractor are not covered under any other Plan benefit except as described on page 5. Chiropractic charges applied to satisfy the deductible are counted toward the benefit limit.

Diagnosis and treatment of infertility

The Plan will pay up to $5,000 per person per lifetime for the following services and supplies:

- Initial diagnostic tests and procedures done solely to identify the cause of the inability to conceive
- Fertility drugs, hormone therapy and related services
- Medical or surgical services performed solely to create or enhance the ability to conceive

Other Medical Benefits *continued*

Durable medical equipment

The Plan pays for rental, up to the purchase price, of durable medical equipment (see definition). Purchase of equipment is at the Plan's option and must also be preapproved. To obtain preapproval, request Plan approval in writing within 31 days of the initial rental and include your doctor's statement of medical necessity. Unless you request an extended rental within 31 days, the Plan will not pay for more than three rental months even if it eventually authorizes purchase of the equipment.

Occupational therapy

Plan pays for up to thirty days of occupational therapy each calendar year when therapy is under the supervision of a doctor.

Smoking cessation benefit

The Plan will pay up to $100 per member per lifetime for enrollment in one smoking cessation program, including any related prescription drugs. Charges applied to satisfy the deductible are counted toward the benefit limit. Smoking cessation drugs and medications are not available under any other Plan provisions.

Well child care

The Plan will pay charges for all routine office visits and testing for children up to age 24 months. See below for benefits for routine childhood immunizations.

What is not covered

- Orthopedic shoes, orthotics and other devices to support the feet
- Corsets and trusses
- Provocative food testing, end point titration techniques and sublingual allergy desensitization
- Sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers, exercise devices and other items that do not meet the definition of durable medical equipment
- Eye exercises and visual training (orthoptics)
- Custodial care
- Telephone consultations
- Jobst stockings, unless determined to be medically necessary

Additional Benefits

Accidental injury or medical emergency

The Plan will pay **100%** of reasonable and customary charges up to a maximum of $200 for treatment of an accidental injury or a medical emergency (see definitions) on an inpatient or outpatient basis if rendered within 72 hours of injury or medical emergency. This can include follow-up charges for dressings, X-ray, and cast removal in connection with injury if initial treatment is received within 72 hours. Charges exceeding the $200 limit will be considered under Other Medical Benefits.

Ambulance service

The Plan will pay actual charges up to $50 for professional ambulance service to the nearest hospital or medical facility which is equipped to handle the patient's condition for accidents or acute illness, or for inpatients in connection with covered inpatient care. Additional charges are covered under Other Medical Benefits.

Cancer treatment

The Plan will pay, without dollar limitation, **100%** of the reasonable and customary charges for any services and supplies normally covered by the Plan for the treatment of any illness diagnosed as cancer. The service or supply must be for the treatment of a malignancy. Diagnoses secondary to cancer are not covered under this benefit.

Childhood immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered at **100%** of reasonable and customary charges for dependent children under age 22. Associated charges for office visits and other services will be considered under Other Medical Benefits.

Consultation

The Plan will pay up to $50 for an in-hospital consultation, limited to one consultation per confinement. Reasonable and customary charges above $50 are covered under Other Medical Benefits.

Additional Benefits *continued*

Dental accident

The Plan will pay **100%** (no deductible) of 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 performed within one year of the accident. If treatment or repair to a child's teeth must be delayed because of the child's age, the Plan may extend coverage to a period of not more than three years from the date of the accident provided the request for delay is made to the Plan within one year of the accident, and the child remains covered by the Plan until treatment is completed.

The Plan may request dental records, including X-rays, to substantiate the condition of the teeth prior to the accidental injury. Charges covered for dental accidents cannot be considered under Dental Benefits.

Home health care

If home health care (see definition) is precertified (see page 24), the Plan will pay **100%** of the reasonable and customary charges up to a maximum of $80 per visit for up to 90 visits per calendar year when the care is an alternative to hospitalization.

If the care is not precertified, the Plan will pay **100%** of the reasonable and customary charges up to a maximum of $40 per visit for up to 40 visits per calendar year when the care is an alternative to hospitalization.

A home health care visit consists of one of the following:

- Less than an 8 hour shift of nursing care provided by a registered nurse (RN) or a licensed practical nurse (LPN);
- One session of physical, occupational or speech therapy provided by a licensed therapist;
- Less than an 8 hour shift of a home health aide's services that are performed under the supervision of a registered nurse(RN) and that consists mainly of medical care and therapy provided solely for the care of the Plan member.

The above services must be furnished by a home health agency (or by visiting nurses where services of a home health agency are not available) in accord with a home health care plan (see definition) certified by the member's doctor and in the member's home.

Hospice care

If hospice care is precertified (see page 24), the Plan will pay **100%** of the reasonable and customary charges up to a maximum of $7,500 for care provided by a hospice agency or organization (see definition) to a terminally ill patient in the final stages of illness when such care is prescribed by a doctor.

If the care is not precertified, the Plan will pay **100%** of the reasonable and customary charges up to a maximum of $5,500 when hospice care is prescribed by a doctor.

Outpatient surgical facility

The Plan will pay **100%** of charges for the use of an outpatient surgi-center or other outpatient surgical facility, including a doctor's office. The doctor's charge for surgery is covered under Surgical Benefits (page 11).

Renal dialysis

The Plan will pay **100%** of reasonable and customary charges for covered services and supplies for renal dialysis in or out of the hospital.

Skilled nursing facilities

If a person is confined in a skilled nursing facility and the confinement is precertified (see page 24), the Plan will, for a maximum of 60 days per calendar year, pay **100%** of the reasonable and customary charges when the confinement is an alternative to hospitalization.

If a person is confined in a skilled nursing facility but the confinement is not precertified, the Plan will, for a maximum of 30 days per calendar year, pay **80%** of the reasonable and customary charges when the confinement is an alternative to hospitalization.

Vision care

The Plan will pay up to $45 per person per calendar year for one routine eye examination, including eye refraction, if part of the routine exam. Please note that the itemized bill must indicate that the visit is for the purpose of a routine exam.

Prescription Drug Benefits

What is covered

You may purchase the following medications and supplies prescribed by a doctor from either a pharmacy or by mail:

- Drugs that by Federal law of the United States require a doctor's prescription for their purchase
- Insulin
- Needles and syringes for the administration of covered medication
- Ostomy and colostomy supplies

What is not covered

- Medical supplies such as dressings and antiseptics
- Drugs and supplies for cosmetic purposes
- Nutritional supplements, vitamins
- Contraceptive drugs and devices, including Norplant
- Fertility drugs, after the Plan's payment for the treatment of infertility has met the $5,000 lifetime maximum
- Drugs to aid in smoking cessation except under Smoking cessation benefit (see page 16)
- Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law
- Drugs to treat sexual dysfunction and impotence

From a pharmacy

You may purchase up to a 34-day supply of covered drugs or supplies at a discount through a Caremark Retail Network Pharmacy or pay full price at a non-network pharmacy. Call 800/831-4440 to locate a network pharmacy in your area. You pay the cost of a prescription at the time of purchase. The expense is reimbursed at **75%** after the $250 deductible has been met.

To claim benefits

Use Plan claim form HCFA 1500 to claim benefits for prescription drugs and supplies you purchased at any network or non-network retail pharmacy. You may obtain claim forms by calling 800/638-8432. Complete and sign the claim form, attach prescription receipts and mail it to: Rural Carrier Benefit Plan, P.O. Box 668329, Charlotte, NC 28266-8329. Your receipt must show the name of the patient, prescription number, name of drug, prescribing doctor's name, date, charge, and name of pharmacy.

By mail

If your doctor orders more than a 34-day supply of drugs or covered supplies, up to a 90-day supply, you may order your prescription or refill by mail from the Rural Carrier Benefit Plan mail order drug program. Caremark will fill your prescription. All drugs and supplies covered by the Plan are available under this program except drugs to aid in smoking cessation and fertility drugs.

Under the Rural Carrier Benefit Plan mail order drug program, if a generic equivalent to the prescribed drug is available, Caremark will dispense the generic equivalent instead of the name brand unless your doctor specifies that the name brand is medically required. You pay a $15 copayment for each brand name prescription drug, a $10 copayment for each generic prescription drug or refill you purchase through the Plan's mail order drug program.

Medicare copayment

You pay a $5 copayment for each brand name or a $2 copayment for each generic prescription drug or refill when you are covered by Medicare Part B and use the Plan's mail order drug program.

To claim benefits

The Plan will send you information on the mail order drug program. To use the program:

1) Complete the initial mail order form.
2) Enclose your prescription and copayment.
3) Mail your order to: Caremark, P.O. Box 659572, San Antonio, TX 78265-9572
4) Allow approximately two to three weeks for delivery.

You'll receive forms for refills and future prescription orders each time you receive drugs or supplies under this program. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call toll-free: 800/831-4440.

Drugs from other sources

Prescription drugs are also covered at **75%** after the $250 deductible has been met under this Plan when they are provided to you by a doctor or covered facility.

Purchasing drugs when you are overseas

Only prescription drugs and supplies available in the United States and listed above as covered by the Plan are eligible for reimbursement when purchased in a foreign country. These expenses are reimbursed at **75%** after the $250 deductible has been met.

Dental Benefits

What is covered

The Plan will pay for the following services on the Class A and Class B schedules of dental allowances. These lists include all covered services.

Preventive care

Class A schedule of dental allowances

Plan pays — Actual charges for up to two visits per person per calendar year up to the amounts specified below; you pay any charges that exceed Plan payment.

Oral exam	$12.50	Complete X-ray series	$34.00
Prophylaxis, adult	$22.00	Panoramic X-ray	$34.00
Prophylaxis, child (thru age 14)	$15.00	Single film X-ray	$ 5.50
with fluoride treatment	$24.00	Each additional X-ray film (up to 7)	$ 4.00
Space maintainer	$88.00	Bitewings – 2 films	$ 9.00
		Bitewings – 4 films	$14.00

Restorative care

Class B schedule of dental allowances

You pay a deductible of $50 per person per calendar year and any charges that exceed Plan payment; Plan pays actual charges up to the amounts specified below.

Restorations		**Root canal therapy**	
Amalgam – 1 surface deciduous	$12.50	One root	$106.00
Amalgam – 2 surfaces deciduous	$18.50	Two roots	$126.00
Amalgam – 3 or more surfaces deciduous	$23.50	Three or more roots	$170.00
Amalgam – 1 surface permanent	$14.00	Gingival curettage (per quadrant)	$ 26.50
Amalgam – 2 surfaces permanent	$20.50	**Crowns**	
Amalgam – 3 or more surface permanent	$26.50	Plastic with gold	$120.00
Silicate cement	$13.50	Porcelain	$113.50
Acrylic or plastic	$21.50	Porcelain with gold	$120.00
Gold	$103.50	Gold (full cast)	$120.00
Extractions (uncomplicated)		Gold (3/4 cast)	$120.00
Single tooth	$16.00	Stainless steel	$ 21.50
Each additional tooth	$15.00	**Dentures**	
Pulp capping – direct	$ 9.50	Complete upper or lower	$126.00
Pulpotomy – vital	$21.00	Partial without bar	$138.00
Pontics		Partial with bar	$157.00
Porcelain fused to gold	$120.00	Repairs	$ 14.00
Dowel pin	$ 25.00	Relining	$ 40.50

Where this schedule provides for a category of service, but does not specifically list a particular procedure belonging in that category, the Plan will determine the maximum allowance for that procedure. Services of a dentist are not covered under any other Plan benefit except as described above and on pages 12 and 17.

Related benefits

Dental accident

For dental accident benefit, see page 17.

Oral surgery

For covered oral surgery, see page 12.

What is not covered

- Charges related to orthodontia
- Dental procedures involving the preparation of the mouth for dentures, including routine tooth extractions
- Dental implants
- Dental appliances, study models, splints and other devices or services related to the treatment of TMJ dysfunction
- Other dental services not listed as covered
- Any service covered under another provision of the Plan

How to Claim Benefits

Claim forms, identification cards and questions

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier at 703/684-5552 to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you have a question concerning Plan benefits, contact the Carrier at 800/638-8432.

Claim forms will be furnished with your identification cards. Claim forms will also be furnished with all claim payments. Additional forms may be obtained by writing to the Plan at 1630 Duke Street, First Floor, Alexandria, VA 22314-3466 or calling 800/638-8432.

How to file claims

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA 1500, Health Insurance Claim Form. Claims submitted by enrollees may be submitted on the HCFA 1500 or a claim form that includes the information shown below. 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
- Type of each service or supply and the charge
- Diagnosis

In addition:

- A copy of the explanation of benefits (EOB) or Medicare Summary Notice (MSN) from any primary payer must be sent with your claim.
- Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse and must include nursing notes.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and medicines that are not ordered through the mail order drug program must include receipts that include the prescription number, name of drug, prescribing doctor's name, date, charge and name of the pharmacy.
- Claims for overseas (foreign) 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.
- If the claim involves hospitalization, the hospital billing statement must show (or the hospital must advise) the type of accommodations (private, semiprivate, etc.). If a private room is used, the billing statement must show the average semiprivate rate.

Canceled checks, cash register receipts or balance due statements are not acceptable.

Complete a claim form HCFA 1500. Note the name of the insured the same as it appears on the ID card. Be sure to answer all questions or mark "Not Applicable" (N/A) on those which do not apply every time you file a claim.

The attending doctor or dentist must complete the statement on the HCFA 1500 or furnish another statement which includes the name of the patient, the diagnosis, dates of treatment, itemized charges and the Federal Tax ID number of the doctor or dentist. There is no separate prescription drug or dental claim form.

After completing claim form HCFA 1500 and attaching the doctor's or dentist's statement and all related itemized bills, send claims to:

Rural Carrier Benefit Plan
P. O. Box 668329
Charlotte, NC 28266-8329
Claims toll-free telephone number: 800/638-8432
Plan Administrative Office telephone number: 703/684-5552

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 all medical bills including those being accumulated to satisfy a deductible. In most instances they will serve as evidence of your claim. The Carrier will not provide duplicate or year end statements.

Submit claims promptly

Claims must be filed within 90 days after the expense for which the claim is being made was incurred. To avoid delays in payment, submit claims as expenses are incurred. **Do not hold claims until the end of the year.** Expenses are "incurred" on the date on which the service or supply is received. No benefits are payable for claims submitted to the Plan more than two (2) years from the date the expense is incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

A finding of custodial care by the Plan does not exclude benefits for all services and supplies. Some services (such as prescription drugs, X-rays and lab tests) may still be covered. **ALL BILLS SHOULD BE ROUTINELY SUBMITTED TO THE PLAN FOR CONSIDERATION.**

Once benefits have been paid, there is a three year limitation on the reissue of uncashed checks.

Direct payment to hospital or provider of care

An assignment to direct benefit payments to the hospital or doctor may be made by completing an assignment form furnished by the hospital or doctor or by completing the assignment statement on claim form HCFA 1500.

When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available.

Confidentiality

Medical and other information provided to the Carrier, including claim files, is kept confidential and will be used only: 1) by the Carrier and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education. As part of its administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

Disputed claims review

Reconsideration

If a claim for payment is denied by the Carrier, you must ask the Carrier, in writing, and within six months of the date of the denial, to reconsider its decision before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Carrier an opportunity to reconsider your claim. Before you ask the Carrier to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly. For instance, did they use the correct procedure code for the service(s) performed (surgery, laboratory test, X-ray, office visit, etc.)? Indicate any complications of any surgical procedure(s) performed. Include copies of an operative or procedure report, or other documentation that supports your claim. Your written request to the Carrier should state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment should have been paid.

Within 30 days after receipt of your request for reconsideration, the Carrier must affirm the denial in writing to you, pay the claim, or request additional information that is reasonably necessary to make a determination. If the Carrier asks a provider for information it will send you a copy of this request at the same time. The Carrier has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Carrier will base its decision on the information it has on hand.

OPM review

If the Carrier affirms its denial, you have the right to request a review by OPM to determine whether the Carrier's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Carrier's letter affirming its initial denial.

You may also ask OPM for a review if the Carrier fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Carrier. In this case, OPM must receive a request for review within 120 days of your request to the Carrier for reconsideration or of the date you were notified that the Carrier needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the Carrier should have paid the denied claim. If the Carrier has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Carrier requesting reconsideration;
- A copy of the Carrier's reconsideration decision (if the Carrier failed to respond, provide instead (a) the date of your request to the Carrier, or (b) the dates the Carrier requested and you provided additional information to the Carrier);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms, etc.); and
- Your daytime phone number.

Medical documentation received from you or the Carrier during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P. O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement - If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of OPM's decision on the disputed claim.

Protection Against Catastrophic Costs

Catastrophic protection

For those services with coinsurance, the Plan pays **100%** of reasonable and customary charges for the remainder of the calendar year after the calendar year deductible is met, when out-of-pocket expenses for the deductibles and coinsurance in that calendar year exceed $2,500 per person or $3,000 per family.

Out-of-pocket expenses for the purposes of this Benefit are:

- The 15% you pay for Surgical Benefits;
- The 20% you pay for Inpatient Hospital Benefits;
- The 25% you pay for Other Medical Benefits;
- The $250 you pay toward the Other Medical Benefits calendar year deductible; and
- The $200 you pay toward the first hospital admission deductible under Inpatient Hospital Benefits.

The following cannot be included in the accumulation of out-of-pocket expenses:

- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Expenses for mental conditions, substance abuse or dental care;

- Expenses incurred for medications ordered through the Rural Carrier mail order drug program;
- Expenses for non-covered services and supplies; and
- Expenses for confinement in a skilled nursing facility
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see page 24).

Mental Conditions/ Substance Abuse Benefit

For Mental conditions, after the **50%** you pay for inpatient care after the 31st day, plus the $400 deductible, total $8,000 in a calendar year for an individual, the Plan will then pay **100%** of covered hospital charges for that individual for the remainder of the calendar year.

Carryover

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

Other Information

Precertification

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. It is your responsibility to ensure that precertification is obtained. If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500.

To precertify a scheduled admission:

- You, your representative, your doctor, or your hospital must call Mutual of Omaha's Care Review Unit at least seven days prior to admission. The toll-free number is 800/228-0286.
- 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 of hospital or facility; name and phone number of admitting doctor; and number of planned days of confinement.

Mutual of Omaha's Care Review Unit will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation of the Carrier's certification decision will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Need additional days?

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional inpatient days are medically necessary. If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to not be medically necessary by the Carrier during the claim review.

You don't need to certify an admission when

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 7 and 25). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- You are confined in a hospital outside the United States.

Maternity or emergency admissions

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone 800/228-0286 within two business

Precertification *continued*

days following the day of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits payable for the admission will be reduced by $500.

Newborn confinements that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued confinement within two business days following the day of the mother's discharge.

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless the Carrier is misled by the information given to it. After the claim is received, the Carrier will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If you do not precertify

If precertification is not obtained before admission to the hospital (or within two business days following the date of a maternity or emergency admission or in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary the inpatient hospital benefits will not be paid. However, medical supplies and services otherwise payable on an outpatient basis will be paid.

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by $500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medical services and supplies otherwise payable on an outpatient basis will be paid.

Precertify home health care, hospice care and skilled nursing care

When home health care, hospice care or skilled nursing care are prescribed by a doctor, you, your representative, the doctor, the home health agency, hospice agency, or skilled nursing facility must telephone Mutual of Omaha's Care Review Unit at 800/228-0286 for a predetermination that, based on the information given, the care meets the medical necessity requirements of the Carrier. Otherwise, benefits payable for the care will be reduced.

Information You Have the Right to Know

All carriers in the FEHB Program must provide certain information to you. If you do not receive information about this Plan, you can obtain it by calling the Carrier at 800/638-8432 or you may write the Carrier at 1630 Duke Street, First Floor, Alexandria, VA 22314-3466.

Information that must be made available to you includes:

- Disenrollment rates for 1997.
- Carrier's type of corporate form and years in existence.

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this plan and Medicare (see page 7).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

The following rules apply to enrollees and their family members who are entitled to benefits from both an FEHB plan and Medicare.

This Plan is primary if:

1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;

3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD), except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or
4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and that you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Medicare is primary if:

1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;
2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;
3) You are 65 or over and (a) you are a Federal judge who retired under title 28 of the U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26 of the U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);
4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;
5) You are enrolled in Part B only, regardless of your employment status;
6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);
7) You 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;
8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or
9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1 through 7 above.

When Medicare is primary

When Medicare is primary, all or part of your Plan deductibles and coinsurance will be waived as follows:

Inpatient Hospital Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.

Surgical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the coinsurance.

Mental Conditions/Substance Abuse Benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.

Other Medical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance applicable to medical care. Note: prescription drugs are not covered by Medicare; therefore, neither the deductible nor the coinsurance for prescription drugs is waived.

Prescription Drugs: If you are enrolled in Medicare Part B, this Plan will reduce the copayment you pay under the Rural Carrier mail order drug program from $10 to $2 per prescription for generic prescriptions and from $15 to $5 for brand name prescriptions.

Dental Benefits: A person enrolled in Medicare is required to satisfy the dental deductible.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its 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 enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

This Plan and Medicare *continued*

When you also enroll in a Medicare prepaid plan

When you are enrolled in a Medicare prepaid plan while you are a member of this Plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims.

Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Doctors who participate with Medicare accept assignment; that is, they have agreed not to bill you for more than the Medicare-approved amount for covered services. Some doctors who do not participate with Medicare accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid only when the Medicare and Plan payments combined do not total the Medicare-approved amount.

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the limiting charge, is 115 percent of the Medicare-approved amount. Under this law, if you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid only if the Medicare and Plan payments combined do not total the limiting charge. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. The Medicare Summary Notice (MSN) form will have more information about this limit.

If your doctor does not participate with Medicare and asks you to pay more than the limiting charge, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the Medicare MSN statement. In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115 percent of the Medicare-approved amount.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. The Carrier has contracted with all Medicare Part B carriers to receive electronic copies of your claims after Medicare has paid their benefits. This eliminates the need for you to submit your Part B claims to this Carrier. You may call the Carrier at 800/638-8432 to find out if your claims are being electronically filed. If they are not, you should initially submit your claims to Medicare and, after Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses upon receipt of the itemized bill and Medicare Summary Notice (MSN) statement. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare MSN statement.

Enrollment Information

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How to file claims" on page 20.

If you are a new member of this Plan, benefits begin on the effective date of your enrollment, as set by your employing office or retirement system (see Effective date on page 30). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see "If you are hospitalized" on page 27.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision, or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan. If you changed plans or plan options, see "If you are a new member" on page 26. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.
- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Carrier promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 26 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

Federal annuitants are not required to enroll in Medicare Part B(or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she will generally be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Certificate of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date, and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements:

- **Separating employees** - Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.
- **Children** - You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example the child reaches age 22 or marries.
- **Former spouses** - You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices is available - or chosen - when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, for example divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Definitions

Accidental injury

An injury caused by an external force such as a blow or a fall and that requires immediate medical attention. Animal bites and poisonings are also included as is dental care required as a result of an accidental injury to sound natural teeth. An injury to the teeth while eating is not considered an accidental injury.

Admission

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

Assignment

An authorization by an enrollee or spouse for the Carrier to issue payment of benefits directly to the provider. The Carrier reserves the right to pay the member directly for all covered services.

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.

Confinement

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

Congenital anomaly

A condition existing at or from birth which is a significant deviation from the common form or norm. For purposes of this Plan, congenital anomalies include cleft lips, cleft palates, birth marks, webbed fingers or toes and other conditions that the Carrier may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

Cosmetic surgery

Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through change in bodily form.

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1) personal care such as help in: walking, getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
2) homemaking, such as preparing meals or special diets;
3) moving the patient;
4) acting as companion or sitter;
5) supervising medication that can usually be self administered; or
6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

1) are prescribed by your attending doctor;
2) are medically necessary;
3) are primarily and customarily used only for a medical purpose;
4) are generally useful only to a person with an illness or injury;
5) are designed for prolonged use; and
6) serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

The date the benefits described in this brochure are effective:

1) January 1 for continuing enrollments;
2) for new enrollees in the Plan, the effective date of enrollment is determined by the employing office or retirement system of the enrollee.

Definitions *continued*

Expense

The cost incurred for a covered service or supply ordered or prescribed by a doctor. An expense is incurred on the date the service or supply is received. Expense does not include any charge: 1) for a service or supply that is not medically necessary, or 2) that is in excess of the reasonable and customary charge for the service or supply.

Experimental or investigational drug, device and medical treatment or procedure

Experimental or investigational:

- A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. 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 1) 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 2) 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.

Group health coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.

Home health care

A plan of continued care and treatment of an insured person who is under the care of a doctor, and whose doctor certifies that without home health care, confinement in a hospital or skilled nursing facility would be required. Home health care must be provided by a public agency or private organization that is licensed as a home health agency by the State and is certified (or is qualified and could be certified) as such under Medicare.

Hospice care program

A coordinated program of home and inpatient pain control and supportive care for the terminally ill patient and the patient's family, provided by a medically supervised team under the direction of a Carrier approved independent hospice administration.

Medical emergency

The sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical care that the covered person secures within 72 hours after the onset. Medical emergencies include deep cuts, broken bones, heart attacks, cardiovascular accidents (strokes), poisonings, loss of consciousness or respiration, convulsions, and such other acute conditions as may be determined by the Carrier to be medical emergencies.

Medically necessary

Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Carrier determines:

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

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Mental conditions/ substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders or personality disorders; other nonpsychotic mental disorders listed in the ICD, to be determined by the Carrier; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

Morbid obesity

A condition in which an individual:

1) is greater than 100 pounds or 100% over the standard weight as determined by the Carrier's underwriter, with complicating medical condition(s), and
2) has been so for at least five years, despite documented unsuccessful attempts to reduce weight under a diet and exercise program monitored by a doctor.

Prosthetic appliance

A device which is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. Prosthetic appliances include such items as artificial legs, artificial hips, artificial knees, and pacemakers.

Reasonable and customary

Those charges that are comparable to charges made by other providers for similar services and supplies under comparable circumstances in the same geographic area. The Carrier's allowances are developed from actual claims received in each Zip Code area throughout the United States, as compiled by the Health Insurance Association of America, and are updated twice a year, at the 90th percentile. This method is used for determining reasonable and customary allowances for surgery, maternity, physician and other professional services, Other Medical and Mental Conditions/Substance Abuse Benefits, and accidental injury care. For other categories of benefits, and for certain specific services within each of the above categories, exceptions to this general method for determining the Plan's allowances may exist.

Sound natural tooth

A tooth that is whole or properly restored and is without impairment, periodontal disorders or other dental disorders and is not in need of the treatment provided for any reason other than an accidental injury.

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims review procedure.

Long term care

Long term care is open to NRLCA members under the age of 80. Premium rates are based on your age at the time of acceptance into the program. Please consult the separate descriptive pamphlet for detailed information.

- Covers confinements for skilled nursing, intermediate nursing and custodial care. $100 per day benefit
- Covers nonconfinement care for: home health care, adult day care and respite care. $50 per day benefit
- Contains return of premium feature
- Contains inflation protection option

Term life insurance

Term life insurance is open to active postal employees who are members of the NRLCA under age 60. Premium rates are based on your age at time of acceptance into the program 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

Long term disability income insurance

Long term disability income insurance protects an individual from being unable to work because of an illness on injury. Long term disability coverage is open to active regular rural letter carriers who are members of the NRLCA. Premium rates are based on age and coverage option selected. Please consult the separate descriptive pamphlet for detailed information.

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

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
703/684-5552

Benefits on this page are not part of the FEHB contract

How the Rural Carrier Benefit Plan Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide Changes:

- Several changes have been made in compliance with the President's mandate to implement the recommendations of the Patient Bill of Rights.
- The medical management of mental conditions will be covered under this Plan's Other Medical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychotherapy will be covered under this Plan's Mental Conditions Benefits. Initial psychological testing is covered under this Plan's Other Medical Benefits.
- If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.
- The definition of experimental or investigational (see page 31) has been clarified to include biological products.
- The States designated as medically underserved have changed for 1999. Idaho and North Dakota have been added, and West Virginia is no longer underserved. See page 5 for information on medically underserved areas.

Changes to this Plan:

- Under Mental Conditions/Substance Abuse, the amount payable by the Plan for outpatient care for mental conditions has increased from $40 to $75 per session.
- Under Mental Conditions/ Substance Abuse, the Plan has added a benefit for partial hospitalization as a medically necessary alternative to inpatient care. See page 14 for more details.
- Under the "Accidental injury or medical emergency" provision of "Additional Benefits", the Plan will now cover surgical care. Previously, the Plan's definition of "Medical emergency" only provided coverage of medical emergency services for non-surgical medical care. See page 31 for the Plan's revised definition of medical emergency.

Summary of Benefits for the Rural Carrier Benefit Plan – 1999

Do not rely on this chart alone. All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $250 calendar year deductible.

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	After a $200 deductible per person for the first admission in a calendar year, 100% of room and board and 80% of all other covered hospital charges for each confinement	10
	Surgical	85% of reasonable and customary charges	11,12
	Medical	75%* of reasonable and customary charges	15
	Maternity	Same benefits as for illness and injury	13
	Mental conditions	After you pay the first $400 of covered hospital charges per person per calendar year, 100% of covered hospital charges for the first 31 days and 50% of covered charges after the 31st day	14
	Substance abuse	Up to $5,500 per inpatient treatment program in an accredited alcohol or drug abuse treatment facility (limited to two programs per lifetime)	14
Outpatient care	**Hospital**	100% of reasonable and customary charges for surgery facility, 75%* of other hospital charges	15,17
	Surgical	85% of reasonable and customary charges	11,12
	Medical	75%* of reasonable and customary charges	15,16,17
	Maternity	Same benefits as for illness and injury	13
	Home health care	100% of the reasonable and customary charges up to a maximum of $80 per visit for up to 90 visits in a calendar year	17
	Mental conditions	Up to $75 per session (not subject to deductible or coinsurance)	14
	Substance abuse	Up to $250 for an aftercare treatment program that immediately follows the inpatient treatment program	14
Emergency care (accidental injury)		Up to $200 of charges for treatment of injury that was incurred within 72 hours of the accidental injury	16
Prescription drugs		Under Other Medical Benefits, the Plan pays 75%* and you pay 25% of reasonable and customary charges. Under the mail order drug program, you pay $10 generic, $15 name brand per prescription or refill ($2 generic, $5 name brand if you are covered by Part B of Medicare)	18
Dental care		Benefits for preventive and restorative services listed on dental schedules	19
Additional benefits		Hospice care, Home Health care, Vision care, Cancer treatment, Ambulance service, Childhood immunizations, Inhospital consultations, Renal dialysis, Skilled nursing facility care, Dental accident	16,17
Protection against catastrophic costs		100% of covered charges under Inpatient Hospital, Surgical and Other Medical Benefits after expenses reach $2,500 out-of-pocket per individual or $3,000 per family in a calendar year or after you spend $8,000 on covered hospital charges under Mental conditions for one person in one year	22,23

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United States Office of Personnel Management

Federal Employees Health Benefits Program

1999 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 most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate member of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		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**	**156.13**	**73.80**	**84.98**	**21.14**
High Option Self and Family	**382**	**n/a**	**n/a**	**347.51**	**121.23**	**183.29**	**33.05**