Rural Carrier Benefit Plan

www.RCBPhealth.com

Customer Service 800-638-8432

2027

A Fee-for-Service Plan with Network Providers

This Plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 7 for details. This Plan is accredited. See page Section 1, *How This Plan Works.*

IMPORTANT
- Rates: Back Cover
- Changes for 2027: Page 14
- Summary of Benefits: Page 128

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

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

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

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

Enrollment codes for this Plan:

79A High Option – Self Only
79C High Option – Self Plus One
79B High Option – Self and Family

PSHB

Authorized for distribution by the:

United States
Office of Personnel Management

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

RI 72-012

Important Notice for Medicare-eligible Active Employees from PSHB Rural Carrier Benefit Plan About Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the PSHB Rural Carrier Benefit Plan's prescription drug coverage for active employees meets the Centers for Medicare & Medicaid Services (CMS) requirements to be considered Creditable Coverage. This means active employees and their covered family members do not need to enroll in an open market Medicare Part D plan and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your PSHB coverage as an active employee.

However, if you (as an active employee and your covered Medicare Part D-eligible family members) choose to enroll in an open market Medicare Part D Plan, you can keep your PSHB coverage and your PSHB Plan will coordinate benefits with Medicare.

Please be advised

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

Medicare's Low Income Benefits

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

Additional Premium for Medicare's High Income Members

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

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

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

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Introduction

This brochure describes the benefits of Rural Carrier Benefit Plan under contract (CS 1073PS) between The National Rural Letter Carriers' Association (NRLCA) and the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law, as amended by the Postal Service Reform Act, which created the Postal Service Health Benefits (PSHB) Program. This Plan is underwritten by Claims Administration Corporation, an Aetna company. Customer service may be reached at 800-638-8432 or through our website www. RCBPhealth.com. If you are deaf, hearing impaired or speech impaired, you can contact Customer Service at 800-638-8432, TTY 711. If you need ASL providers see our website at www. RCBPhealth.com. The address for Rural Carrier Benefit Plan administrative offices is:

Rural Carrier Benefit Plan
1630 Duke Street, 2nd Floor
Alexandria, VA 22314-3466

This brochure is the official statement of benefits. No verbal statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self Plus One or Self and Family coverage, each eligible family member is also entitled to these benefits. If you are a Postal Service annuitant and you are eligible for Medicare Part D, or a covered Medicare Part D-eligible family member of a Postal Service annuitant, your prescription drug benefits are provided under our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) or our Medicare Advantage Prescription Drug Plan (MAPD) if you choose to enroll in our MAPD option designed specifically for RCBP members. You do not have a right to benefits that were available before January 1, 2027, under the FEHB Program unless those benefits are also shown in this PSHB Plan brochure.

OPM negotiates benefits and rates for each plan annually. Benefit changes are effective January 1, 2027 and changes are summarized in Section 2. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means the Rural Carrier Benefit Plan.
- We limit acronyms to ones you know. OPM is the United States Office of Personnel Management. The FEHB Program is the Federal Employees Health Benefits Program administered by OPM and established under 5 U.S.C. chapter 89. The PSHB Program is the Postal Service Health Benefits Program established within the FEHB Program under 5 U.S.C. section 8903c. PSHB Plan means a health benefits plan offered under the PSHB Program. PSHB means Postal Service Health Benefits. If we use others, we tell you what they mean.
- Our brochure and other PSHB Plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of healthcare for everyone and increases your Postal Service Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the PSHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

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

- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your doctor to make false entries on certificates, bills, or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800-638-8432 and explain the situation.
  - If we do not resolve the issue:

Call --The Healthcare Fraud Hotline

877-499-7295
OR go to www. opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

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

You can also write to:

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

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

Discrimination is Against the Law

We comply with applicable Federal nondiscrimination laws and do not discriminate on the basis of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information. We do not exclude people or treat them differently because of race, color, national origin, age, disability, religion, sex, pregnancy, or genetic information.

The health benefits described in this brochure are consistent with applicable laws prohibiting discrimination. All coverage decisions will be based on nondiscriminatory standards and criteria. An individual's protected trait or traits, will not be used to deny health benefits for items, supplies, or services that are otherwise covered and determined to be medically necessary.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

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

- Ask your surgeon:
  “Exactly what will you be doing?”
  “About how long will it take?”
  “What will happen after surgery?”
  “How can I expect to feel during recovery?”
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

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

Preventable Healthcare Acquired Conditions (“Never Events”)

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

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

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

Coverage information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this Plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

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

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

  See https://health-benefits.opm.gov/PSHB/ for enrollment information as well as:

  - Information on the PSHB Program and plans available to you
  - A health plan comparison tool

  Note: Contact the USPS for information on how to enroll in a PSHB Program Plan through the PSHB System.

  Also, your employing or retirement office can answer your questions, give you other plans' brochures and other materials you need to make an informed decision about your PSHB coverage. These materials tell you:

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

  We do not determine who is eligible for coverage. You will be responsible for making changes to your enrollment status through the PSHB System. In some cases, your employing or retirement office may need to submit documentation. For information on your premium deductions, you must also contact your employing or retirement office.

  Once enrolled in your PSHB Program Plan, you should make any enrollment changes in the PSHB System located https://health-benefits.opm.gov. If you are unable to access your PSHB account online contact your employing office at 877-477-3273 or retirement office at 888-767-6738. If you have any questions about your benefit coverage contact us directly.

- **Enrollment types available for you and your family**

  Self Only coverage is only for the enrollee. Self Plus One coverage is for the enrollee and one eligible family member. Self and Family coverage is for the enrollee and one or more eligible family members. Family members include your spouse and your children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

  If you have a Self Only enrollment, you may change to a Self Plus One or Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self Plus One or Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member.

You enroll in a PSHB Program Plan and make enrollment changes in the PSHB System located at https://health-benefits.opm.gov. If you are unable to access your PSHB account online contact your employing office at 877-477-3273 or retirement office at 888-767-6738. When you change to Self Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment request. Benefits will not be available to your spouse until you are married. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Use the PSHB System if you want to change from Self Only to Self Plus One or Self and Family, and to add or remove a family member. Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits. Please, report changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26 through the PSHB System. We will send written notice to you 60 days before we proactively disenroll your child on midnight of their 26th birthday unless your child is eligible for continued coverage because they are incapable of self-support due to a physical or mental disability that began before age 26.

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

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

- **Family Member Coverage**

Family members covered under your Self and Family enrollment are your spouse (including your spouse by a valid common-law marriage from a state that recognizes common-law marriages) and children as described below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described below.

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

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

Children incapable of self-support
Coverage: Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.

Married children
Coverage: Married children (but NOT their spouse or their own children) are covered until their 26th birthday.

Children with or eligible for employer-provided health insurance
Coverage: Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

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

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

- **Children's Equity Act**

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

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

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

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

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

  For annuitants who are required to be enrolled in Medicare Part B as a condition to continue PSHB coverage in retirement: If you enroll in Medicare Part B and continue PSHB coverage in retirement, the child equity law applies to you and you cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your child(ren) live as long as the court/administrative order is in effect. You cannot be compelled to enroll or remain enrolled in Medicare Part B to maintain your PSHB enrollment as a condition to satisfy a court/administrative order. However, if you do not enroll (or remain enrolled) in Medicare Part B as required to continue your PSHB coverage in retirement (notwithstanding an existing court/administrative order), you will not be able to continue your PSHB coverage in retirement.

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

  Our PDP EGWP is only available to Postal Service annuitants who are Medicare Part D-eligible, enrolled in this Plan and their covered Medicare Part D-eligible covered family members. Our PDP EGWP is not an open market Medicare Part D Plan. If you are an active Postal Service employee, or covered family member, and become eligible to enroll in Medicare Part D, you are not eligible to enroll in our PDP EGWP. Please contact CMS for assistance at 800-633-4227 or visit www.cms.gov. You may also contact us at 833-825-6754 for additional information.

- **When benefits and premiums start**

  The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage and premiums begin on January 1. If you joined at any other time during the year, your employing or retirement office will tell you the effective date of coverage.

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

- **When you retire**

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

When you lose benefits

- **When PSHB coverage ends**

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

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

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

If you are eligible for coverage under spouse equity, you are only eligible to enroll in the FEHB Program. If you are not eligible for coverage under spouse equity and you are otherwise eligible for Temporary Continuation of Coverage (TCC), then you could enroll in TCC under the PSHB Program.

- **Upon divorce**

If you are an enrollee and your divorce or annulment is final, your ex-spouse cannot remain covered as a family member under your Self Plus One or Self and Family enrollment. You must enter the date of the divorce or annulment and remove your ex-spouse in the PSHB System. We may ask for a copy of the divorce decree as proof. If you need to change your enrollment type, you must use the PSHB System. A change will not automatically be made.

If you were married to an enrollee and your divorce or annulment is final, you may not remain covered as a family member under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). Former spouses eligible for coverage under the spouse equity law are **not** eligible to enroll in the PSHB Program. However, former spouses eligible for coverage under the spouse equity law may enroll in the FEHB Program. (Former Spouses seeking but not yet adjudicated as eligible for Spouse Equity may be entitled to TCC under a PSHB Plan in the interim).

Former spouses not meeting the spouse equity requirements may be eligible for TCC under the PSHB Program provided you otherwise meet the eligibility requirements for TCC. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get additional information about your coverage choices, www.opm.gov/healthcare-insurance/life-events/memy-family/im-separated-or-im-getting-divorced/#url=Health. We may request that you verify the eligibility of any or all family members listed as covered under the enrollee's PSHB enrollment.

Medicare PDP EGWP

When a Postal Service annuitant who is Medicare Part D-eligible or their covered Medicare Part D-eligible family member opts out of or disenrolls from our PDP EGWP, they will not have our prescription drug coverage under this Plan. If you do not maintain credible coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for additional information at 833-825-6754.

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

  If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your PSHB enrollment after you retire, if you lose your Federal job, or if you are a covered child and you turn age 26, regardless of marital status, etc.

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

  Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll. Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing PSHB Program coverage.

- **Converting to individual coverage**

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

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

- **Health Insurance Marketplace**

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

Section 1. How This Plan Works

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

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

General features of our High Option

We have Network Providers:

Our fee-for-service Plan offers services through our network providers. This means that certain hospitals and other healthcare providers are "in-network providers". When you use our in-network providers, you will receive covered services at reduced cost. Aetna is solely responsible for the selection of network providers in your area. The Plan uses the Aetna Choice POS II (Open Access) network. We encourage you to choose a primary care provider to assist in coordinating your medical care in the safest and most cost-effective manner. Contact us at 800-638-8432 or go to our website, www. RCBPhealth.com for the names of network providers and to verify their continued participation or to request a network directory for your area.

The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use an in-network provider. Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. Participating physicians, hospitals and other healthcare providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network participation is subject to change. If no network provider is available, or you do not use a network provider, the standard out-of-network benefits apply. When you use a network facility, keep in mind that the healthcare professionals who provide services to you in the facility may not be in-network providers in our network. However, if the services are received at a network facility, we will pay up to the Plan allowance at the In-network provider level of benefits for services you receive from an out-of-network anesthesiologist (including Certified Registered Nurse Anesthetist (CRNA)), radiologist, pathologist, emergency room physician, hospitalists, intensivists, surgeon and neonatologist when immediate or emergency treatment is required. You will still be responsible for the difference between our benefit payment and the billed amount. Follow these procedures when you use an in-network provider in order to receive in-network benefits:

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

This Plan offers you access to certain out-of-network healthcare providers that have agreed to discount their charges. Covered services provided by these participating providers are considered at the negotiated rate subject to applicable deductibles, copayments and coinsurance. Since these participating providers are not considered in-network providers, out-of-network benefit levels will apply. Contact us at 800-638-8432 for more information about participating providers.

The Plan has networks in all states. The Plan uses the Aetna Choice POS II network. Please check the Plan website at: www. RCBPhealth.com or call Aetna at 800-638-8432 for network providers.

How we pay providers

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

We use National Standardized Criteria Sets and other nationally recognized guidelines and resources in making determinations regarding inpatient hospital, acute rehabilitation, residential treatment precertification, and therapies that require prior approval (see Section 3. You need prior Plan approval for certain services). These determinations can affect how we provide benefits.

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

Your rights and responsibilities

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

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

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

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

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

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

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

Your medical and claims records are confidential

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

You may view our Notice of Privacy Practice for more information about how we may use and disclose member information by visiting our website at: www. RCBPhealth.com.

Section 2. New for 2027

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

Changes to this Plan:

- Your share of the premium rate will increase for Self Only, Self Plus One and Self and Family. See *back cover.*
- The Plan updated the list of services that require precertification or prior approval. See Section 3. *How You Get Care* for more information.
- The Plan no longer offers an exception process for sex-trait modification.
- The Plan modified the Telephonic Health Coaching for Weight Management. See Section 5(f). *Prescription Drug Benefits* for more information.

Changes to Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan:

- The Plan is increasing the Medicare Part B premium reduction from $75 per month to $100 per month for members enrolled in our Medicare Advantage Prescription Drug (MAPD) plan option.

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the PSHB System enrollment confirmation. Note: If you are enrolled in our Medicare Part D PDP EGWP, you will receive a separate ID card for your prescription drug benefits.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-638-8432 or write to us at Rural Carrier Benefit Plan, 1630 Duke Street, 2nd Floor, Alexandria, VA 22314-3466. You may also request replacement cards through our website: www.RCBPhealth.com.

Where you get covered care

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

Balance Billing Protection

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

- **Covered providers**

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

Benefits are provided under this Plan for the services of covered providers, in accordance with Section 2706(a) of the Public Health Service Act. Coverage of practitioners is not determined by your state's designation as a medically underserved area.

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

Benefits described in this brochure are available to all members meeting medical necessity guidelines regardless of race, color, national origin, age, disability, religion, sex, pregnancy or genetic information.

This Plan provides Care Coordinators for complex conditions and can be reached at 800-638-8432 for assistance or visit https://rcbphealth.com/care-management-programs/ for additional information.

- **Covered facilities**

Covered facilities include:

Hospital:

1. An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO); or
2. Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hour-a-day nursing service, and that is primarily engaged in providing:

- General inpatient care and treatment of sick and injured persons through medical, diagnostic, and major surgical facilities, all of which facilities must be provided on its premises or under its control; or
- Specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

In no event shall the term hospital include a convalescent nursing home or institution or part thereof that:

1. Is used principally as a convalescent facility, rest facility, nursing facility, or facility for the aged;
2. Furnishes primarily domiciliary or custodial care, including training in the routines of daily living; or
3. Is operated as a school.

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

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

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

Hospice: A public or private agency or organization that:

1. Administers and provides hospice care; and
2. Meets one of the following requirements

- Is licensed or certified as a hospice by the State in which it is located;
- Is certified (or is qualified and could be certified) to participate as a hospice under Medicare;
- Is accredited as a hospice by the JCAHO; or
- Meets the standards established by the National Hospice Organization.

- **Transitional care**

Specialty care: You may continue seeing your specialist and receiving any in-network benefits for up to 90 days if you are undergoing treatment for a chronic or disabling condition and you lose access to your specialist because:

- we drop out of the PSHB Program and you enroll in another PSHB Plan (or become covered as a family member under a FEHB enrollment), or
- we terminate our contract with your specialist for reasons other than for cause,

Contact us at 800-638-8432 or if we drop out of the PSHB Program, contact your new plan.

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

Note: If you lose access to your specialist because you changed your carrier or plan option enrollment, contact your new plan.

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

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

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

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

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

You need prior Plan approval for certain services

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

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

- **Inpatient hospital admission**

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

In most cases, your physician or hospital will take care of requesting precertification. Because you are still responsible for ensuring that your care is precertified, you should always ask your physician or hospital if they have contacted us.

Warning

We will reduce our benefits for the inpatient hospital, Skilled Nursing Facility stay or residential treatment care by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will only pay for any covered medical services and supplies that are otherwise payable on an outpatient basis.

Exceptions

You do not need precertification in these cases:

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

Other services

Some services require precertification or prior approval. For a complete list refer to www.aetna.com/health-care-professionals/precertification/precertification-lists.html.

Please call 800-638-8432 for approval for:

- Advance Reproductive Technology (ART) infertility services (including iatrogenic infertility)
- Ambulance – prior approval required for transportation by fixed-wing aircraft (plane)

- Autologous chondrocyte implantation, Carticel
- BRCA genetic testing
- Certain mental health services, inpatient admissions, Residential treatment center (RTC) admissions, Transcranial magnetic stimulation (TMS) and Applied Behavior Analysis (ABA)
- Chemotherapy
- Chiari malformation decompression surgery
- Cochlear device and/or implantation
- Covered transplant surgeries
- Dialysis visits – when request is initiated by an in-network provider, and dialysis to be performed at an out-of-network facility
- Dorsal column (lumbar) neurostimulators; trial or implantation
- Electric or motorized wheelchairs and scooters
- Endoscopic nasal balloon dilation procedures
- Gene therapy, gene editing and gene silencing
- Hip surgery to repair impingement syndrome
- Hyperbaric oxygen therapy
- Inpatient confinements (except hospice) For example, surgical and non-surgical stays; stays in a skilled nursing or rehabilitation facility; and maternity and newborn stays that exceed the standard length of stay (LOS)
- Lower limb prosthetics
- Observation stays 24 hours or more
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint (TMJ)
- Out-of-network freestanding ambulatory surgical facility services, when referred by an in-network provider
- Osseointegrated implant
- Osteochondral allograft/knee
- Pediatric Congenital Heart Surgery
- Proton beam radiotherapy
- Radiology imaging such as CT scans, MRIs and MRAs
- Reconstructive or other procedures that may be considered cosmetic, such as:
  - Blepharoplasty/canthoplasty
  - Breast reconstruction/breast enlargement
  - Breast reduction/mammoplasty
  - Cervicoplasty
  - Excision of excessive skin due to weight loss
  - Gastroplasty/gastric bypass
  - Lipectomy or excess fat removal
  - Surgery for varicose veins, except stab phlebectomy
- Shoulder arthroplasty
- Specialty medications*
- Spinal procedures, such as:
  - Artificial intervertebral disc surgery
  - Cervical, lumbar and thoracic laminectomy/laminotomy procedures
  - Sacroiliac joint fusions

- Spinal fusion surgery
- Vertebral corpectomy

- Uvulopalatopharyngoplasty, including laser-assisted procedures
- Ventricular assist devices

Note: The Plan works with providers to assist in determining the best setting for medical services to ensure safe, effective care at the right cost, covering infusion, injection, radiology, and specialized therapies. For more information, refer to: https://www.aetna.com/healthcare-professionals/utilization-management/drug-infusion-siteof-care-policy.html

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

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

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

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

Next, provide the following information:

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

- **Non-urgent care claims**

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

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

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

- **Urgent care claims**

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

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of time frame, whichever is earlier.

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 800-638-8432. You may also call OPM's Postal Service Insurance Operations (PSIO) at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 800-638-8432. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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

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

- **Emergency inpatient admission**

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

- **Maternity care**

You do not need precertification of a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 3 days after admission for a vaginal delivery or 5 days after admission for a cesarean section, then your doctor or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, your physician or the hospital must contact us for precertification of additional days for your baby.

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

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

If your hospital stay – including for maternity care or residential treatment care – needs to be extended, you, your representative, your doctor or the hospital must ask us to approve the additional days. If you remain in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

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

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

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

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If your claim is in reference to a contraceptive, call 800-292-4182.

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

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

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

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

1. Precertify your hospital stay or, if applicable, arrange for the healthcare provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information. You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision you have the right to appeal. See Section. 8(a) for information about the PDP EGWP appeal process.

Section 4. Your Costs for Covered Services

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

Cost-sharing

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

Copayment

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

Example: When you see your in-network physician you pay a copayment of $20 per visit for a primary care provider and $35 per day for a specialist provider. If you see more than one in-network physician on the same day, you pay one copayment for each different physician seen on that day. When you have a stay in an in-network hospital, you pay $200 for the first day of your hospital stay and for an out-of-network hospital; you pay $400 for the first day of your hospital stay. The $400 does not apply to out-of-network hospital stays for mental health and/or substance use disorders.

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

Deductible

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

- The calendar year deductible for In-network services is $350 per person and for Out-of-network services it is $800 per person. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $350 for In-network services or $800 for Out-of-network services under High Option. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $700 for In-network services or $1,600 for Out-of-network services under High Option. Under a Self and Family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $700 for In-network services and $1,600 for Out-of-network services. Any expenses incurred that apply toward deductibles for in-network or out-of-network apply toward both in-network and out-of-network limits.
- We have a separate prescription drug deductible of $200 per person each calendar year that applies to all covered prescription drugs that you purchase at a retail drugstore or pharmacy. The prescription drug deductible of $200 does not apply to members who have Medicare A and B as primary coverage.
- We also have a separate deductible for dental care of $50 per person each calendar year.

Note: If you change PSHB Plans during Open Season the effective date of your new PSHB plan is January 1 of the next year, and a new deductible starts on January 1. If you change plans at another time during the year, you must begin a new deductible under your new plan.

Coinsurance

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

Example: You pay 30% of our allowance for office visits under our out-of-network benefit.

If your provider routinely waives your cost

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

For example, if your physician ordinarily charges $100 for a service but routinely waives your 30% coinsurance, the actual charge is $70. We will pay $49 (70% of the actual charge of $70).

Waivers

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

Differences between our allowance and the bill

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

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

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

- In-network providers agree to limit what they will bill you. Because of that, when you use a network provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see an in-network physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, you pay just – 15% of our $100 allowance ($15). Because of the agreement, your In-network physician will not bill you for the $50 difference between our allowance and the bill.

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

- Verify with us that your home address is correct
- When you make an appointment, verify that the physician or facility is still a network provider
- Present your Rural Carrier Benefit Plan PSHB ID card at the time that you receive services to receive in-network benefits
- Generally, you do not pay an in-network provider at the time of service, except for any copayment that you owe. In-network providers must bill us directly. We must reimburse the provider directly. In-network providers will then bill you for any balance due after our payment to them.
- Out-of-network providers, on the other hand, have no agreement to limit what they will bill you. When you use an out-of-network provider, you will pay your deductible and coinsurance – plus any difference between our allowance and charges on the bill. Here is an example: You see an out-of-network physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our $100 allowance ($30). Plus, because there is no agreement between the out-of-network physician and us, the physician can bill you for the $50 difference between our allowance and the bill.

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

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

EXAMPLE:

Network physician

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

Out-of-network physician

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

You should also see in this section under *Important Notice About Surprise Billing - Know Your Rights* for a description of your protections against surprise billing under the No Surprises Act.

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

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

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

If you are enrolled in RCBP's SilverScript Employer Prescription Drug Plan (PDP), you will have a separate $2,000 out-of-pocket maximum. Once you reach the maximum, you will no longer pay a cost share for covered drugs. The $2,000 maximum applies to the Plan's out-of-pocket maximum.

For members enrolled in our Plan's associated EGWP, we are required to accumulate your actual out-of-pocket costs for covered drugs, services, and supplies toward the PSHB catastrophic maximum, unless specifically excluded in your plan documents.

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

- Expenses for dental care
- Expenses in excess of our allowances or maximum benefit limits
- Any penalty you pay for failing to get approval for a hospital stay or residential treatment care

- Any amount you pay for failing to get approval for additional days in the hospital after the initial length of a hospital stay is approved
- Expenses you pay for services, supplies and drugs not covered by us
- Expenses covered by specialty drug copay assistance cards

Carryover

If you changed to this PSHB Plan during Open Season from a plan with a catastrophic protection benefit the effective date of the change is January 1, and covered expenses that apply to this Plan's catastrophic protection benefit starts on January 1.

Note: If you change PSHB Plans during Open Season the effective date of your new PSHB Plan is January 1 of the next year, and a new catastrophic protection accumulation starts on January 1. If you change plans at another time during the year, you must begin a new catastrophic protection accumulation under your new plan.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

If we overpay you

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

When Government facilities bill us

Facilities of the Department of Veteran Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Important Notice About Surprise Billing – Know Your Rights

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

A surprise bill is an unexpected bill you receive for:

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

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

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

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

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

Section 5. High Option Benefits

See Section 2 for how our benefits changed this year. Page 128 provides a benefits summary for our High Option plan. Make sure that you review the benefits available under this Plan.

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Section 5. High Option Benefits Overview

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

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

RCBP High Option includes:

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

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

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

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

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

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

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

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Healthcare Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: In-network: $350 for Self Only; $700 for Self Plus One and Self and Family. Out-of-network: $800 for Self Only; $1,600 for Self Plus One and Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use a network provider. When no network provider is available, out-of-network benefits apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The coverage and cost-sharing listed below are for services provided by physicians and other health care professionals for your medical care. See Section 5(c) for cost-sharing associated with the facility (i.e., hospital, surgical center, etc.).
- You must get precertification or prior approval for certain services in this Section, such as, but not limited to: electric or motorized wheelchairs, cochlear devices and/or implantation, BRCA genetic testing, CT scans, MRIs, and MRAs. Please refer to the precertification information shown in Section 3 for additional services requiring prior approval.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your PSHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of $100 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

Benefits Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	**High Option**
Professional services of physicians, telehealth consultations (except surgery) • In physician's office • In a CVS Minute Clinic (primary care visit) • Medical consultations • In dentist's office in relation to covered oral and maxillofacial surgical procedures • Hearing treatment related to non-auditory illness or disease Note: Primary care providers are limited to general practitioners, family practitioners, internists and pediatricians.	In-network primary care provider: $20 copayment (No deductible) In-network specialist provider: $35 copayment (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Diagnostic and treatment services - continued on next page

Benefits Description	You pay After the calendar year deductible…
Diagnostic and treatment services (cont.)	**High Option**
Note: Preauthorization is required for certain specialty drugs. See Section 3, *How you get care* for information on specialty drugs administered in your physician's office or an outpatient setting. Note: We pay for surgery services by a physician under Section 5(b), *Surgical services*. Note: Telehealth consultations are covered when your provider uses a Health Insurance Portability and Accountability Act (HIPAA) compliant tool for facilitating telehealth consultations. Supplies, other than diabetic supplies, provided by a physician during an office visit are covered under Section 5 (a) of the brochure. See Section 5(a), under *durable medical equipment* for coverage of diabetic supplies. *Outpatient physical therapy, occupational therapy, and speech therapy* are covered under Section 5(a). Treatment for *Mental and Behavioral Health Disorders and Substance Use Disorder* is covered under Section 5(e).	In-network primary care provider: $20 copayment (No deductible) In-network specialist provider: $35 copayment (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Injections	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Outpatient care in an urgent care facility because of a medical emergency Note: We pay medical supplies, medical equipment, prosthetic and orthopedic devices for use at home under Section 5(a), *Medical services and supplies*.	In-network: $35 copayment (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional services of physicians • During a hospital stay or observation stay • In a skilled nursing facility • In your home • In an urgent care center for non-urgent care services Note: We cover contraceptive drugs under *Prescription Drug Benefits*, Section 5(f).	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Professional non-emergency services provided in a walk-in clinic, including telehealth visits (see *Definitions,* Section 10) Note: For services related to an *accidental injury or medical emergency*, see Section 5(d)	In-network: $20 copayment per visit (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
If you are provided drugs (including diabetic drugs) directly by a physician, infusion care provider or durable medical equipment (DME) provider.	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Benefits Description	You pay After the calendar year deductible…
Telehealth Services	**High Option**
Telehealth consultations are available to members in the 50 United States with primary care and specialty providers through Teladoc® such as: • Doctors of Medicine (MD) • Doctors of Osteopathic Medicine (DO) • Dermatologists • Nutritionists • Licensed Clinical Social Workers (LCSW) • Psychiatrists • Psychologists See www.teladoc.com/Aetna or call 855-835-2362 (855-Teladoc) for information regarding consults. See Section 5(h), *Wellness and Other Special Features* for additional information.	In-network: Nothing (No deductible) Out-of-network: No benefit
Not covered: • *Phone consultations, mailing faxes, emails or any other communication to or from a physician, hospital or other medical provider except as provided under Diagnostic and treatment services and Telehealth services.*	*All charges*
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap test • Pathology • X-ray • Non-routine mammogram • CT/CAT Scan • MRI • Ultrasound • Electrocardiogram and EEG • Sonograms • Hearing test for non-auditory illness or disease • Medically appropriate genetic counseling and testing Note: Coverage for urine drug testing or screening is limited to the details provided in "Urine Drug Testing and Screening" on the adult-care page at www. RCBPhealth.com or by calling us at 800-638-8432.	In-network: 15% of Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If your network provider uses an out-of-network lab or radiologist, we will pay out-of-network benefits for any lab and X-ray charges. Note: For genetic testing for prescription drugs see Section 5 (h), *Wellness and Other Special features*.

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

Benefits Description	You pay After the calendar year deductible…
Lab, X-ray and other diagnostic tests (cont.)	**High Option**
Note: The Plan offers confidential phone and web based genetic counseling services. These services are offered through Informed DNA, a national genetic counseling company staffed with independent board certified genetic counselors. For more information or to schedule an appointment for genetic counseling, call Informed DNA at 800-975-4819.	In-network: 15% of Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If your network provider uses an out-of-network lab or radiologist, we will pay out-of-network benefits for any lab and X-ray charges. Note: For genetic testing for prescription drugs see Section 5 (h), *Wellness and Other Special features*.
CT/CAT scans, CTA, MRA, MRI, NC, PET, SPECT, provided at a stand-alone imaging center or clinic Note: Prior approval for these procedures is required except in the case of an accident or medical emergency. Call us at 800-638-8432 prior to scheduling. See *Radiology Imaging* under *You need prior Plan approval for certain services*, Section 3, *Other services*. Note: If a stand-alone in-network imaging center or clinic is not used, the regular Lab, X-Ray and diagnostic tests benefits above apply. Call us at 800-638-8432 for more details and information about stand-alone imaging centers. Note: Expenses for related professional services are covered under this benefit.	In-network: 5% of Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Lab Savings Program	**High Option**
You may use this voluntary program for covered outpatient lab tests if Quest Diagnostics or LabCorp performs the testing. Show your RCBP identification card each time you obtain lab work and tell your physician you would like to use Quest Diagnostics or LabCorp. If the physician draws the specimen, they can call Quest Diagnostics at 866-697-8378 or LabCorp at 888-522-2677 for pick up or you can go to an approved collection site and show your RCBP ID card along with the test requisition from your physician and have the specimen drawn there. Note: To find an approved collection site near you, call Quest Diagnostics at 866-697-8378 or LabCorp at 888-522-2677 or search for Quest Diagnostics or LabCorp using your Zip Code in the Plan's online provider search tool at www. RCBPhealth.com.	In-network: Nothing (No deductible) Out-of-network: No benefit Note: This benefit applies to expenses for lab tests only. Related expenses for services by a physician (or lab tests performed by an associated laboratory not participating in the Lab Savings Program) are subject to applicable deductibles and coinsurance.

Benefits Description	You pay After the calendar year deductible…
Preventive care, adult	**High Option**
A routine physical exam – one per person each calendar year. Note: This includes a separate gynecological exam once per calendar year for women. Note: Lab tests and X-rays are covered under Section5 (a). *Lab, Xray and other diagnostic tests*, unless coded as routine. Note: Any additional medical discussion, procedure, injection, diagnostic service, laboratory, or x-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible. **The following preventive services are covered at the time interval recommended at each of the links below unless otherwise stated in this Section:** • U.S. Preventive Services Task Force (USPSTF) A and B recommended screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer. For a complete list of screenings go to the website at https ://www. uspreventiveservicestaskforce.org/uspstf/ recommendation-topics/uspstf-a-and-b-recommendations • Colorectal cancer screening, including: - Fecal occult blood test - Sigmoidoscopy screening - every five years - Colonoscopy screening - every ten years • Individual counseling on prevention and reducing health risks • Prostate cancer screening (PSA) - once per calendar year for members age 40 -69 • Preventive care benefits for women such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of preventive care benefits for women go to the Health and Human Services (HHS) website at www. hrsa.gov/womens-guidelines • Screening and counseling for prenatal and postpartum depression • Routine mammogram	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Preventive care, adult - continued on next page

Benefits Description	You pay After the calendar year deductible…
Preventive care, adult (cont.)	**High Option**
• Routine use of adult immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the CDC. For the current immunization schedule, visit https ://www. cdc.gov/ vaccines/imz-schedules/index.html • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Age and frequency limitations do not apply to cancer screenings if there is a family history or high-risk factor that indicates the need for screenings.	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Obesity counseling, screening and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, including prevention of obesity related co-morbidities • Counseling programs when medically identified to support obesity prevention and management Note: Limited to 26 visits per person per calendar year, visits exceeding the 26 visit limit max will be covered under Section 5(a), *Diagnostic and treatment services.* Note: For additional information regarding prescribed anti-obesity medications see Section 5(f) or 5(f)(a), if applicable. Note: For additional information regarding bariatric surgical treatment or intervention for severe obesity, see Section 5 (b), *Surgical procedures.* Note: See Section 5(h), W*ellness and Other Special Features* for additional programs and wellness incentive opportunities available for nutritional and physical activity support.	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Preventive care, children	**High Option**
For covered dependent children under age 22: • Well-child visits examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org. For preventive immunizations see guidance below. • Routine use of children's immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) and adopted by the Centers for Disease Control and Prevention (CDC) are covered. A recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the CDC. For the current immunization schedule, visit https ://www. cdc.gov/vaccines/imz-schedules/index.html • You may also find a complete list of U.S. Preventive Services Task Force (USPSTF) A and B recommendations online at: www. uspreventiveservicestaskforce.org • Body mass index (BMI) testing for children under age 22 • Medical nutrition therapy and Intensive Behavioral Therapy, including prevention of obesity related comorbidities, unlimited • Hearing screening exam testing, diagnosis and treatment (including hearing aids for hearing loss) • Retinal screening exam performed by an ophthalmologist for infants with low birth weight, less than 1 year of age and with unstable clinical course • To build your personalized list of preventive services go to https://health.gov/myhealthfinder Note: Any additional medical discussion, procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	In-network: Nothing (No deductible) Out-of-network: Nothing up to Plan allowance then the difference between our allowance and the billed amount (No deductible)
Obesity counseling, screening, and referral for those persons at or above the USPSTF obesity prevention risk factor level, to intensive nutrition and behavioral weight-loss therapy, counseling, or family centered programs under the USPSTF A and B recommendations are covered as part of prevention and treatment of obesity as follows: • Intensive nutrition and behavioral weight-loss counseling therapy, including prevention of obesity related co-morbidities, unlimited visits • Counseling programs when medically identified to support obesity prevention and management, unlimited visits	In-network: Nothing (No deductible) Out-of-network: Nothing up to Plan allowance then the difference between our allowance and the billed amount (No deductible)

Preventive care, children - continued on next page

Benefits Description	You pay After the calendar year deductible…
Preventive care, children (cont.)	**High Option**
Note: For additional information regarding prescribed anti-obesity medications see Section 5(f) or 5(f)(a), if applicable. Note: For additional information regarding bariatric surgical treatment or intervention for severe obesity, see Section 5 (b), *Surgical procedures.*	In-network: Nothing (No deductible) Out-of-network: Nothing up to Plan allowance then the difference between our allowance and the billed amount (No deductible)
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure*	*All charges*
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care (including laboratory tests) • Delivery • Anesthesia • Postpartum care • Sonograms • Screening for gestational diabetes • Screening and counseling for prenatal and postpartum depression Note: For facility care related to maternity, see Section 5(c), *Services Provided by a Hospital or Other Facility, and Ambulance Services*. Note: For services related to an *accidental injury or medical emergency*, see Section 5(d).	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If your child is not covered under a Self and Family enrollment, you pay all of your child's charges after your discharge from the hospital.
• Breastfeeding and lactation support, supplies and counseling for each birth • Breastfeeding equipment rental or purchase for each birth Note: Breast pump and supplies are limited to the purchase or rental of standard and hospital grade breastfeeding equipment to an amount no greater than what we would have paid if the equipment had been purchased. We will cover only the cost of standard and hospital grade equipment, which includes the items included in the initial supply kit provided with a new pump order. Note: Breastfeeding supplies such as maternity bras, nursing pads or additional bottles are not covered. Note: When breastfeeding equipment and supplies are purchased at a CVS Pharmacy, you pay nothing (No deductible). Notes:	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Maternity care - continued on next page

Benefits Description	You pay After the calendar year deductible…
Maternity care (cont.)	**High Option**
• You do not need to precertify your vaginal delivery; see Section 3. *How You Get Care* for other circumstances, such as extended stays for you or your baby. • As part of your coverage, you have access to in-network Certified Nurse Midwives (CNM), home nurse visits and board-certified lactation specialists during the prenatal and post-partum period. We cover physical and emotional support provided during pregnancy, childbirth and postpartum by a certified doula. See elsewhere in this Section for additional information. • You may remain in the hospital up to 3 days after admission for a vaginal delivery and 5 days after admission for a cesarean delivery. We will cover an extended stay if medically necessary, but you, your representative, your physician or your hospital must precertify the extended stay. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • We cover the initial routine examination of your newborn infant covered under your family enrollment. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury. • For services related to an a*ccidental injury or medical emergency*, see Section 5(d). • *Hospital services* are covered under Section 5(c) and *Surgical benefits* Section 5(b). Note: When a newborn requires definitive treatment during or after the mother's hospital stay, the newborn is considered a patient in their own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits. Circumcision is covered under Section 5(b), *Surgical procedures.* Note: Maternity care expenses incurred by a Plan member serving as a surrogate mother are covered by the Plan subject to reimbursement from the other party to the surrogacy contract or agreement. The involved Plan member must execute our Reimbursement Agreement against any payment they may receive under a surrogacy contract or agreement. Expenses of the new-born child are not covered under this or any other benefit in a surrogate mother situation. Note: For additional information or support, see Section 5 (h), *Healthy Maternity Program.*	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Maternity care - continued on next page

Benefits Description	You pay After the calendar year deductible…
Maternity care (cont.)	**High Option**
Physical and emotional support provided by a certified doula to our pregnant member (includes prenatal services, childbirth, and up to 3 months postpartum care).	In-network and out-of-network: Nothing up to the Plan maximum of $1,200 per person, per calendar year; then all charges (No deductible)
Medically appropriate genetic counseling and testing is covered under *Maternity care* for maternity related genetic tests. Note: The Plan offers confidential phone and web based genetic counseling services. These services are offered through Informed DNA, a national genetic counseling company staffed with independent board certified genetic counselors. For more information or to schedule an appointment for genetic counseling, call Informed DNA at 800-975-4819.	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: If your child is not covered under a Self and Family enrollment, you pay all of your child's charges after your discharge from the hospital.
Not covered: • *Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest*	*All charges*
Family planning	**High Option**
Contraceptive counseling on an annual basis	In-network: Nothing Out-of-network: Nothing
A range of voluntary family planning services, including patient education and counseling, limited to: • Voluntary female sterilization • Voluntary male sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragms Note: We offer some type of voluntary female sterilization surgery coverage at no cost to members. The contraceptive benefit includes one form of contraception in each of the categories in the HRSA supported guidelines (as well as the screening, education, counseling, and follow-up care). Any type of voluntary female sterilization surgery that is not already available without cost sharing can be accessed through the contraceptive exceptions process described below.	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Family planning - continued on next page

Benefits Description	You pay After the calendar year deductible…
Family planning (cont.)	**High Option**
Visit www. rcbphealth.com/contraception-coverage/ or call us at 800-638-8432 for our contraceptive exception process or for information on our reimbursement for OTC contraceptives (prescription required). Once we have been contacted and have all the required information, we will process your contraceptive exception and you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov. Note: For oral contraceptive drugs and devices, see Section 5 (f), *Prescription Drug Benefits.*	In-network: Nothing (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic testing and counseling*	*All charges*
Infertility services	**High Option**
Infertility services for Artificial Insemination (AI) will be considered medically necessary for any member unable to conceive, regardless of relationship status or sexual orientation. For ovulation induction (OI) and Advanced Reproductive Technology (ART), the Plan will continue to require prior authorization and will utilize Aetna's medical necessity criteria to determine coverage. The Plan will cover AI as a core medical benefit, members will no longer need to meet a definition or obtain prior authorization. The Plan covers two infertility treatment levels which include **Basic Infertility** and **Advanced Reproductive Technology (ART)**. Note: Prior approval is required for **ART** (including iatrogenic infertility). Call us at 800-575-5999 prior to scheduling. See Section 3, *Other services* for additional information. Note: For ART services, you must use a provider who participates in our Institutes of Excellence™ (IOE) Infertility Providers. For additional information regarding the IOE Infertility Providers, please call 800-575-5999 or visit www. aetnainfertilitycare.com. Note: The Plan offers a fertility advocate to support you through your infertility journey. To speak directly with a fertility advocate call 833-415-1709. Note: Drugs for the treatment of infertility are covered under Section 5(f), *Prescription Drug Benefits.*	See benefit description.

Infertility services - continued on next page

Benefits Description	You pay After the calendar year deductible…
Infertility services (cont.)	**High Option**
Basic Infertility • Initial diagnostic tests and procedures done only to identify the cause of infertility, • Medical or surgical procedures done to create or enhance fertility • Artificial insemination (AI) and monitoring of ovulation to include: - Intracervical insemination (ICI) - Intrauterine insemination (IUI) - Intravaginal insemination (IVI)	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Advanced Reproductive Technology (ART) • Ovulation induction (OI) cycle(s) while on injectable medication to stimulate the ovaries • Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services Note: We limit OI to three cycles. An ovulation cycle is an attempt at ovulation induction while on injectable medication to stimulate the ovaries with or without artificial insemination. • In vitro fertilization (IVF) • Embryo transfer and gamete intrafallopian transfer (GIFT) and Zygote intrafallopian transfer (ZIFT) • Intracytoplasmic sperm injection (ICSI) Note: We limit coverage for ART to two (2) complete cycles per calendar year. The Plan defines a cycle as: • One complete fresh IVF cycle with transfer (egg retrieval, fertilization, and transfer of embryo) • One complete GIFT cycle • One complete ZIFT cycle You are eligible for IVF if you meet our medical necessity criteria, which includes: • Natural or artificial insemination would not be expected to be effective, and ART would be expected to be the only effective treatment; or	Institutes of Excellence™ (IOE) Infertility Providers: Nothing up to the Plan maximum for two complete cycles per person, per calendar year; then all charges (No deductible) Out-of-network: No benefit

Infertility services - continued on next page

Benefits Description	You pay After the calendar year deductible…
Infertility services (cont.)	**High Option**
• You have met the requirement for the number of months trying to conceive through egg and sperm contact (For women under 35 years of age, an appropriate trial of egg-sperm contact requires 12 months of regular intravaginal inseminations or 4 cycles of timed intrauterine or intracervical inseminations, documented in the medical record. For women 35 years of age and older, an appropriate trial of egg-sperm contact requires 6 months of regular intravaginal inseminations or 3 cycles of timed intrauterine or intracervical insemination, documented in the medical record); • You have met the requirement for trying to conceive through ovulation induction (3 cycles for women 37 years of age or younger); AND • You or your partner have not gone through voluntary sterilization with or without reversal; AND • Your unmedicated day three (3) Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's Clinical Policy Bulletin (CPB) for Infertility (visit www.RCBPhealth.com to access the CPB – Infertility).	Institutes of Excellence™ (IOE) Infertility Providers: Nothing up to the Plan maximum for two complete cycles per person, per calendar year; then all charges (No deductible) Out-of-network: No benefit
Fertility preservation for iatrogenic infertility: • Procurement of sperm or eggs including medical, surgical and pharmacy claims associated with retrieval; • Cryopreservation of sperm or mature oocytes (Eggs); and • Cryopreservation storage for Embryo(s), Eggs, or sperm	Institutes of Excellence (IOE) Infertility Providers: Nothing up to the Plan allowance (No deductible) Out-of-network: No benefit
Not covered: • *Infertility services after voluntary sterilization* • *Cost of donor sperm* • *Cost of donor egg* • *Elective fertility preservation, such as egg freezing sought due to natural aging* • *Storage costs, except as described above for iatrogenic infertility* • *Costs for obtaining sperm from a person not covered under this Plan* • *Infertility treatment when a successful pregnancy could have been obtained through less costly treatment* • *Infertility treatment when infertility is due to a natural physiologic process such as age-related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two (2) or three (3) of your menstrual cycle or other abnormal testing results as outlined in Aetna's Infertility Clinical Policy*	*All charges*

Infertility services - continued on next page

Benefits Description	You pay After the calendar year deductible…
Infertility services (cont.)	**High Option**
• *Injectable infertility medication including but not limited to menotropins, hCG, and GnRH agonists, except as described in Section 5(f). Prescription Drug Benefit* • *Any ART services not prior approved by the Plan* • *Coverage for services received by a spouse or partner who is not a covered member under the Plan*	*All charges*
Allergy care	**High Option**
• Testing including the RAST test, and treatment, including materials (such as allergy serum) Note: If your physician uses the Quest Diagnostics or LabCorp to test your specimen, you will pay nothing for the lab test. See Section 5(a), *Lab Savings Program.* Note: The allergy services are included in the office visit copayment if performed during an office visit with a network provider.	In-network: • Services in a physician's office --$20 copayment (No deductible) • Services outside the physician's office—15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Allergy injections	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Food tests* • *End point titration techniques* • *Sublingual allergy desensitization* • *Hair analysis*	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy - Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b), *Organ/tissue transplants.* • Intravenous (IV)/infusion therapy – home IV and antibiotic therapy • Human growth hormone therapy (HGHT). - Note: Growth hormone is covered under the prescription drug benefit. • Respiratory and inhalation therapies • Cardiac rehabilitation therapy - Note: We cover only Phase 1 and 2 for cardiac rehabilitation therapy • Biofeedback only when treating incontinence, migraines, pain management, temporomandibular joint (TMJ) and irritable bowel syndrome (IBS).	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: The Plan pays for services, supplies, and tests rendered for the direct treatment of cancer under *Wellness and Other Special features,* Section 5(h). Note: The Plan pays for services, supplies, and testing for kidney (renal) dialysis under *Wellness and Other Special features*, Section 5(h).

Treatment therapies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	**High Option**
Note: Applied Behavioral Analysis (including the assessment) is covered under Section 5(e), *Mental Health and Substance Use Disorder Benefits* and requires prior approval. See Section 3, under *How you get care*. Note: Preauthorization is required for certain specialty drugs. See Section 3, How *you get care* for information on specialty drugs administered in your physician's office or an outpatient setting.	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount Note: The Plan pays for services, supplies, and tests rendered for the direct treatment of cancer under *Wellness and Other Special features,* Section 5(h). Note: The Plan pays for services, supplies, and testing for kidney (renal) dialysis under *Wellness and Other Special features*, Section 5(h).
Services and supplies related to Gene-Based Cellular and other Innovative Therapies (GCIT™) include: • Cellular immunotherapies • Genetically modified oncolytic viral therapy • Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions other than transplants • Human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using: Luxturna® (Voretigene neparvovec), Zolgensma® (Onasemnogene abeparvovec-xioi), Spinraza® (Nusinersen) • Products derived from gene editing technologies, including CRISPR-Cas9 • Oligonucleotide-based therapies including: - Antisense (Example: Spinraza®) - siRNA To receive the in-network level of benefits, you must use a provider who participates in our GCIT Designated Network. Note: Prior approval is required. Call us at 800-638-8432 prior to scheduling. See Section 3, *Other services*. Note: See Section 5(c), *Outpatient hospital or ambulatory surgical center* for services provided by a hospital. Note: The Plan has special arrangements with facilities to provide services and supplies related to GCIT and may provide travel assistance, see Section 5(h), W*ellness and Other Special Features*, GCIT Designated Network. For additional information regarding the GCIT Designated Network, please call 800-638-8432.	GCIT Designated Network: 15% of the Plan allowance Out-of-network: No benefit

Benefits Description	You pay After the calendar year deductible…
Physical, occupational and speech therapies	**High Option**
For physical therapy, speech therapy and occupational therapy: • 90 total combined visits per calendar year Note: We provide physical, occupational and speech therapy for those diagnosed with Autism. Note: For physical, occupational and speech therapy for autism and developmental delays, see Section 5(e), *Physical, occupational and speech therapies*. Note: Inpatient physical, occupational and speech therapies are covered under Section 5(c).	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	**High Option**
Routine hearing exam, including evaluation and diagnostic hearing tests performed by an M.D.,D.O. or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5 (a), *Preventive care, children*. Note: For benefits for adult hearing devices, see Section 5 (a), O*rthopedic and prosthetic devices.*	In-network: Nothing (No deductible) Out-of-network: Nothing (No deductible)
Not covered: • *Hearing aids and related expenses, except as noted above*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• One pair of eyeglasses with standard frames or contact lenses (including fitting) to correct a change in sight caused directly by an accidental eye injury or intraocular surgery (such as for cataracts), within one year of the injury or surgery Note: See *Orthopedic and prosthetic devices* in this section for intraocular lens coverage. Note: Diabetic retinal eye exams are covered under Section 5 (a), *Diagnostic and treatment services.*	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Routine eye exam, including refractions Note: The itemized bill must show that you had a routine eye exam to qualify for this benefit.	In-network: Nothing up to $45, then all charges (No deductible) Out-of-network: Nothing up to $45, then all charges (No deductible)
Not covered: • *Eyeglasses or contact lenses, except as shown above*	*All charges*

Vision services (testing, treatment, and supplies) - continued on next page

Benefits Description	You pay After the calendar year deductible…
Vision services (testing, treatment, and supplies) (cont.)	**High Option**
• *Deluxe lens features for eyeglasses or contact lenses such as special coatings, polarization and UV treatment* • *Eye exercises and orthoptics* • *Refractive eye surgery and related expenses* • *All refractive corneal or intraocular surgeries for vision correction without an underling medical condition*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: 15% of Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Treatment or removal of corns and calluses, or trimming of toenails, except as stated above* • *Orthopedic shoes and other devices to support the feet, except as shown in Section 5(a), Orthopedic and prosthetic devices*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Prosthetic sleeve or sock • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as intraocular lens (IOLs), cochlear implants, bone anchored hearing aids, artificial joints, pacemakers and surgically implanted breast implant following mastectomy Note: Multifocal, accommodating, toric, or other premium intraocular lenses (IOLs) including Crystalens, ReStor, and ReZoom are covered. Note: See Section 5(b) for coverage of the surgery to insert the device and Section 5(c) for services provided by a hospital.	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Up to $500 for wigs needed as a result of chemotherapy or radiation treatment for cancer. Note: This benefit is available once per calendar year.	In-network: Nothing up to $500, then all charges (No deductible) Out-of-network: Nothing up to $500, then all charges (No deductible)
Hearing aids for adults • Adult hearing aids and related services. Note: This benefit is available once every three years. Note: For information on hearing aid discounts through TruHearing, see *Non-PSHB Benefits.*	In-network: Nothing up to $3,000 per adult, then all charges (No deductible) Out-of-network: Nothing up to $3,000 per adult, then all charges (No deductible)

Orthopedic and prosthetic devices - continued on next page

Benefits Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices (cont.)	**High Option**
Foot orthotics • Prescribed by a physician • Custom fitted, including necessary repair and adjustment • Impression casting • Corrective shoes to treat malformation and weakness of the foot	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Corsets, trusses, and other supportive devices, unless we determine their medical necessity*	*All charges*
Durable medical equipment (DME)	**High Option**
Durable medical equipment (DME) is equipment and supplies that: • Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); • Are medically necessary; • Are primarily and customarily used only for a medical purpose; • Are generally useful only to a person with an illness or injury; • Have a therapeutic purpose in the treatment of an illness or injury We cover rental, up to the purchase price, or purchase (at our option), including necessary repair and adjustment, of durable medical equipment, such as: • Oxygen • Dialysis equipment • Hospital beds • Continuous glucose monitors (CGMs) and supplies • Wheelchairs • Crutches • Walkers • Colostomy and ostomy supplies • Diabetic supplies • Elastic stockings and support hose that require a physician's or other healthcare professional's written prescription • Medical foods and nutritional supplements when administered by catheter or nasogastric tube • Seat lift mechanism on a lift chair provided that all of the following criteria are met: - The patient has severe arthritis of the hip or knee or a severe neuromuscular disease	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Durable medical equipment (DME) - continued on next page

Benefits Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	**High Option**
- The seat lift mechanism is part of a physician's treatment plan and is prescribed to improve the patient's condition or stop or delay deterioration in the patient's condition - The patient is incapable of standing up from any chair in the home - After standing, the patient must be able to walk Note: Coverage is limited to the seat lift mechanism only, even if the mechanism is part of a chair. Note: We will only cover the cost of standard equipment. Coverage for specialty items such as all terrain wheelchairs is limited to the cost of the standard equipment. Note: We cover durable medical equipment (DME) at the in-network benefit level only when you use an in-network DME provider or a CVS pharmacy. In-network physicians, facilities, and other pharmacies are not necessarily in-network DME providers. Note: We will cover charges for service contracts for medically necessary durable medical equipment that is purchased or rented.	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Augmentative and alternative communications (AAC) devices such as: • Computer story boards • Light talkers • Enhanced vision systems • Speech aid prosthesis for pediatrics • Speech aid prosthesis for adults • Magnifier viewing system • Script talk reader devices	In-network: Nothing up to a maximum of $1,000 per device per calendar year (No deductible) Out-of-network: Nothing up to a maximum of $1,000 per device per calendar year (No deductible) Note: Limited to one device per person per calendar year
Not covered: • *Sun or heat lamps, whirlpool bath, heating pads, air purifiers, humidifiers, air conditioners and exercise devices* • *Desktop and laptop computers, pagers, personal digital assistants (PDAs), smart phones, and tablet devices (e.g., iPad), or other devices that are not dedicated speech generating devices* • *Oral nutritional supplements that do not require a prescription under Federal law even if your doctor prescribes them or if a prescription is required under your state law*	*All charges*

Benefits Description	You pay After the calendar year deductible…
Home health services	**High Option**
We pay for up to 90 visits per person per calendar year when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed. Note: Services of a licensed social worker are included in the 90 visit calendar year maximum. Note: For physical, occupational and/or speech therapy services performed during a home health visit see Section 5 (a), *Physical, occupational and speech therapy.*	In-network: 15% of the Plan allowance (No deductible). You pay all charges after 90 visits per calendar year. Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible). You pay all charges after 90 visits per calendar year.
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services consisting of only hygiene, feeding, exercising, moving the patient, homemaking, companionship, or giving oral medication;* • *Custodial care as defined in Section 10*	*All charges*
Chiropractic	**High Option**
• Manipulation of the spine and extremities	In-network: $20 copayment per visit (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	**High Option**
Acupuncture for: • Anesthesia • Pain relief • Therapeutic purposes Note: Please see the definition of acupuncture in Section 10.	In-network: 15% of the Plan allowance for up to 30 visits per person each calendar year (No deductible). After 30 visits, you pay all charges. Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount for up to 30 visits per person each calendar year (No deductible). After 30 visits, you pay all charges.
Massage therapy only when performed by a covered provider (see Section 3) limited to 30 visits per person, per calendar year Note: Massage therapy is limited to one visit per day.	In-network: 15% of the Plan allowance for up to 30 visits per person each calendar year (No deductible). After 30 visits, you pay all charges. Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount for up to 30 visits per person each calendar year (No deductible). After 30 visits, you pay all charges.

Alternative treatments - continued on next page

Benefits Description	You pay After the calendar year deductible…
Alternative treatments (cont.)	**High Option**
Note: You are required to submit a claim as outlined in Section 7, F*iling a claim for covered services*. Your claim must include the provider's first and last name, address, therapist's license number or certification number, itemized bill that includes description of services rendered, cost for each service and paid receipt.	In-network: 15% of the Plan allowance for up to 30 visits per person each calendar year (No deductible). After 30 visits, you pay all charges. Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount for up to 30 visits per person each calendar year (No deductible). After 30 visits, you pay all charges.
Not covered: • *Naturopathic services* • *Chelation therapy, except for arsenic, gold, lead or mercury poisoning and the use of desferoxamine for iron poisoning* • *Rolfing* • *Cupping* • *Endermologie* • *Reiki* • *Kinesiology* • *Moxibustion* • *Therapies such as, Flotation Therapy, Craniosacral Therapy, Salt Therapy, and Stretch Therapy* • *Rapid Tension Relief* • *Taping* • *Body Scrubs*	*All charges*
Educational classes and programs	**High Option**
Tobacco Cessation Program • Two quit attempts per calendar year as part of the Plan's tobacco and nicotine cessation Program. The quit attempts include proactive phone counseling and up to four tobacco cessation counseling sessions of at least 30 minutes each in each quit attempt. Note: Over-the-counter (OTC) and prescription medications approved by the FDA to quit smoking (vaping) or other nicotine use can be obtained at no charge, see Section 5(f), Prescription drug benefits for more details. Note: To enroll in the program, contact a Health Coach at 855-553-5109. Coaches are available Monday – Thursday from 8:00 a.m. – 10:00 p.m. E.T. and Friday from 8:00 a. m. – 6:00 p.m. E.T. You may also enroll online at enroll. trestletree.com (passcode: RCBP).	In-network: Nothing (No deductible) Out-of-network: Nothing (No deductible)
Diabetic education • Diabetic education and training program	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Educational classes and programs - continued on next page

Benefits Description	You pay After the calendar year deductible…
Educational classes and programs (cont.)	**High Option**
Telephonic Health Coach Program The Telephonic Health Coach program provides you and your covered dependents the opportunity to work one-on-one with a Health Coach to improve your health. A Health Coach is a healthcare professional who partners with you to transform your health goals into action. Your Health Coach will provide guidance, support, and resources to help you overcome obstacles that may be keeping you from realizing optimal health. You can talk to a Health Coach about the following health-related matters: • Tobacco cessation • Weight management • Exercise • Nutrition • Stress management • Pain management and opioid support • Chronic conditions such as high blood pressure, high cholesterol, asthma and diabetes To enroll in a program, contact a Health Coach at 855-553-5109. Coaches are available Monday through Thursday from 8:00 a.m. – 10:00 p.m. ET and Friday from 8:00 a.m. – 6:00 p.m. ET. You may also enroll online atenroll.trestletree.com(passcode: RCBP). See the Plan's benefit, Telephonic Health Coach Program, in Section 5(h), *Wellness and Other Special features* for more information.	In-network: Nothing (No deductible) Out-of-network: No benefit
Not covered: • *Body composition analysis* • *Nutritional supplements or food, except those covered under Section 5(a), Durable medical equipment* • *Non-prescription drugs or supplies* • *Exercise or weight loss programs and exercise equipment* • *Services that are not medically necessary*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: **In-network:** $350 for Self Only; $700 for Self Plus One and Self and Family. **Out-of-network:** $800 for Self Only; $1,600 for Self Plus One and Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use a network provider. When no network provider is available, out-of-network benefits apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The services listed below are for the charges billed by a physician or other healthcare professional for your surgical care. See Section 5(c) for charges associated with a facility (i.e. hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES INCLUDING, BUT NOT LIMITED TO: BARIATRIC SURGERY AND ORGAN/TISSUE TRANSPLANTS.** Please refer to the precertification information shown in Section 3 for additional services requiring prior approval.
- **YOU MUST GET PRECERTIFICATION FOR INPATIENT SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your PSHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of $100 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

Benefits Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Surgical procedures • Treatment of fractures, including casting • Routine pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Circumcision	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefits Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**High Option**
• Treatment of burns Note: See Section 5(a), *Family Planning* for voluntary sterilization procedures.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Bariatric Surgery Surgical treatment of severe obesity (Bariatric surgery)-- a condition in which a person (1) has a Body Mass Index (BMI) equal to or greater than 40 or a BMI equal to or greater than 35 with other illnesses such as hypertension, heart disease, diabetes, sleep apnea, nonalcoholic steatohepatitis (NASH) or hyperlipidemia, and; (2) has been under at least one physician supervised weight loss program for 12 or more sessions and occurred within 2 years prior to surgery. The program should be multi-disciplinary by combining diet and nutritional counseling with an exercise program and a behavior modification program. Note: Prior approval is required. Call us at 800-638-8432 for more information. See Section 3, *Other services.* Note: Insertion of internal prosthetic devices. See Section 5 (a), *Orthopedic and prosthetic devices* for device coverage information.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
When multiple surgical procedures are performed during the same operative session by the same surgeon, our benefits are: • For the primary procedure: the Plan's allowance • For the secondary procedure: 50% of the Plan allowance (unless the network contract or other participating provider contract provides for a different amount) • For tertiary and subsequent procedures: 25% of the Plan's allowance (unless the provider is an in-network or other participating provider in the United States and their contract provides for a different amount) Note: Multiple surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	In-network: 15% of the Plan allowance for the primary procedure (No deductible) Out-of-network: 30% of the Plan allowance for the individual procedure and any difference between our allowance and the billed amount

Surgical procedures - continued on next page

Benefits Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**High Option**
Co-surgeons When the surgery requires two surgeons with different skills to perform the surgery, the Plan's allowance for each surgeon is 62.5% of what it would allow a single surgeon for the same procedure(s), unless the network contract or other participating provider contract provides for a different amount.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Assistant Surgeons Assistant surgical services provided by a surgeon (M. D. or D.O.) when medically necessary to assist the primary surgeon. When a surgery requires an assistant surgeon, the Plan's allowance for the assistant surgeon is 16% of the allowance for the surgery, and is 12% of the allowance for the surgery when provided by a nonphysician (such as but not limited to physician assistant, nurse practitioner, or clinical nurse specialist) or when minimum surgical assistant services are provided (unless the network contract or other participating provider contract provides for a different amount).	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *All refractive eye surgeries and similar services* • *Dental appliances, study models, splints, and other devices or service related to the treatment of TMJ dysfunction* • *Treatment or removal of corns and calluses, or trimming of toenails* • *Mutually exclusive procedures-- surgical procedures that are not generally performed on one patient on the same day* • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury, see Section 5(d), Accidental injury*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance; and - the condition can reasonably be expected to be corrected by such surgery	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Reconstructive surgery - continued on next page

Benefits Description	You pay After the calendar year deductible…
Reconstructive surgery (cont.)	**High Option**
• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - Surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses; and surgical bras and replacements (see Section 5(a), *Prosthetic devices* for coverage). Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Mutually exclusive procedures-- surgical procedures that are not generally performed on one patient on the same day* • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury see Section 5(d), Accidental injury* • *Surgery for Sex-Trait Modification to treat gender dysphoria* • *Reversal of gender affirming surgery*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of pathological tori, tumors, and premalignant and malignant lesions • Excision of impacted (unerupted) teeth, including anesthesia • Excision of cysts and incision of abscesses when done as independent procedures • Oral surgical biopsy	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Oral and maxillofacial surgery - continued on next page

Benefits Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	**High Option**
• Surgical correction of temporomandibular joint (TMJ) dysfunction • Frenectomy and frenotomy not as a result of orthodontic care	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Oral implants and transplants and related services* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
These **solid organ and tissue transplants** are covered and limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart/lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung single/bilateral/lobar • Pancreas	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
These **tandem blood or marrow stem cell transplants** for covered transplants are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior approval procedures. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Blood or marrow stem cell transplants The Plan extends coverage for the diagnoses as indicated below. • **Allogeneic transplants** for	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Myeloproliferative disorders - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • **Autologous transplants for** - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Breast cancer - Ependymoblastoma	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Ewing's sarcoma - Medulloblastoma - Multiple myeloma - Neuroblastoma - Pineoblastoma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors - Waldenstorm's macroglobulinemia	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Mini-transplants (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Please see Section 3, *Other services* for prior approval procedures. • **Allogeneic transplants for:** - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced Myeloproliferative Disorders (MPDs) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • **Autologous transplants for:** - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence if approved by the Plan's medical director in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, X-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. • **Allogeneic transplants for:** - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Chronic inflammatory demyelination polyneuropathy (CIDP) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Sickle cell anemia • **Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for:** - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) - leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Multiple sclerosis - Myelodysplasia/Myelodysplastic Syndromes	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Myeloproliferative disorders (MDDs) - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas - Sickle cell anemia • **Autologous Transplants for:** - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Aggressive non-Hodgkin lymphomas - Breast Cancer - Childhood rhabdomyosarcoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) - Multiple sclerosis - Small cell lung cancer - Systemic lupus erythematosus - Systemic sclerosis • **Autologous transplants for the following autoimmune diseases:** - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis - Scleroderma - Scleroderma-SSc (severe, progressive) Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Organ/tissue transplants - continued on next page

Benefits Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
Note: All allowable charges incurred for a surgical transplant, whether incurred by the recipient or donor, will be considered expenses of the recipient and will be covered the same as for any other illness or injury subject to the limits stated above. This benefit applies only if we cover the recipient and if the donor's expenses are not covered under any other health plan for transplants. Note: We cover donor screening and search expenses for up to four (4) candidate donors per transplant in addition to testing family members. Note: Aetna has special arrangements with transplant facilities to provide services for tissue and organ transplants (see Section 5(h), *Wellness and Other Special features, Institutes of Excellence*). The transplant network is designed to give you the opportunity to access providers that demonstrate high quality medical care for transplant patients. We also may assist you and one family member or caregiver with travel and lodging arrangements if you use one of our Institutes of Excellence. Your physician can coordinate arrangements by calling Aetna at 800-638-8432.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organ* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Physician's office Note: When multiple anesthesia providers are involved during the same surgical session, the Plan's allowance for each anesthesia provider will be determined using the Center for Medicare and Medicaid (CMS) guidelines. Note: We cover anesthesia services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not cover the services of dentists, physicians or other healthcare professionals in connection with the dental treatment.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: **In-network:** $350 for Self Only; $700 for Self Plus One and Self and Family. **Out-of-network:** $800 for Self Only; $1,600 for Self Plus One and Self and Family. The Out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use a network provider. When no network provider is available, Out-of-network benefits apply.
- Be sure to read Section 4, Your Costs for Covered Services for valuable information about how cost sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b), unless billed by the facility.
- When you use a network facility, keep in mind that the healthcare professionals who provide services to you in the facility may not be network providers in our provider network. However, if the services are received at a network facility, we will pay up to the Plan allowance at the network provider reimbursement level for services you receive from an Out-of-network radiologist, anesthesiologist (including a Certified Registered Nurse Anesthetist (CRNA)), emergency room physician, hospitalists, intensivists, surgeon, neonatologist and pathologist when immediate or emergency treatment is required. You will be responsible for the difference between our benefit payment and the billed amount.

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

- **YOUR NETWORK PHYSICIAN OR HOSPITAL MUST PRECERTIFY HOSPITAL OR SKILLED NURSING FACILITY STAYS AND FOR CONCURRENT REVIEW (FOR DAYS BEYOND THE PLAN'S INITIAL APPROVAL) FOR IN-NETWORK FACILITY CARE; YOU MUST PRECERTIFY HOSPITAL OR SKILLED NURSING FACILITY STAYS AND FOR CONCURRENT REVIEW FOR OUT-OF-NETWORK FACILITY CARE; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY FOR OUT-OF-NETWORK FACILITY CARE. Please refer to the precertification information shown in Section 3 to confirm which services require precertification.**
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your PSHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of $100 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

Benefits Description	You pay After the calendar year deductible...
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Inpatient hospital	**High Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, then we will consider the private room rate. Note: An overnight stay in a hospital does not always mean you are admitted as an inpatient. You are considered an inpatient the day your physician formally admits you to a hospital with a doctor's order. Whether you are an inpatient or outpatient affects your out-of-pocket expenses. Always ask if you are an inpatient or outpatient at the hospital. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Rehabilitative services • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services Note: We base payment on whether the facility or a healthcare professional bills for the services or supplies. For example, when the anesthesiologist bills, we pay Anesthesia benefits. If preadmission testing is performed in the hospital as inpatient then we pay preadmission tests at the same coinsurance rate as inpatient miscellaneous charges, unless billed by the facility.	In-network: $200 copayment for each hospital admission (No deductible) (copayment waived for a maternity stay) Out-of-network: $400 copayment for each hospital admission and 30% of the Plan allowance (No deductible)
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition in Section 10), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for other medically necessary services and supplies you received other than room and board and in-hospital physician care at the inpatient level.*	*All charges*

Inpatient hospital - continued on next page

Benefits Description	You pay After the calendar year deductible...
Inpatient hospital (cont.)	**High Option**
• *Hospital charges for non-covered surgery* • *Custodial care (see definition in Section 10) even when provided in a hospital* • *Non-covered facilities, such as nursing homes, rest homes, convalescent homes, facilities for the aged, and schools* • *Personal comfort items, such as phone, television, radio, newspapers, air conditioner, beauty and barber services, guest meals and beds* • *Private nursing care during a hospital stay*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms, including observation care less than 24 hours • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment to safeguard the health of the patient, even though we may not cover the services of dentists, physicians or other healthcare professionals in connection with the dental treatment. We base payment on whether the facility or a healthcare professional bills for the services or supplies. For example, when the physician bills for surgery, we pay surgery benefits.	In-network: 15% of the Plan allowance (cost-share is waived for maternity services) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Outpatient observation care 24 hours or more performed and billed by a hospital or freestanding ambulatory facility. Note: All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. See Section 5(a) for *services billed by professional providers* during an observation stay.	In-network: $200 copayment for each hospital admission (No deductible) (copayment waived for a maternity stay) Out-of-network: $400 copayment for each hospital admission and 30% of the covered charges (No deductible)
Services and supplies related to Gene-Based Cellular and other Innovative Therapies (GCIT™) include:	GCIT Designated Network: 15% of the Plan allowance Out-of-network: No benefit

Outpatient hospital or ambulatory surgical center - continued on next page

Benefits Description	You pay After the calendar year deductible...
Outpatient hospital or ambulatory surgical center (cont.)	**High Option**
• Cellular immunotherapies • Genetically modified oncolytic viral therapy • Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions other than transplants • Human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using: Luxturna® (Voretigene neparvovec), Zolgensma® (Onasemnogene abeparvovec-xioi), Spinraza® (Nusinersen) • Products derived from gene editing technologies, including CRISPR-Cas9 • Oligonucleotide-based therapies including: - Antisense (Example: Spinraza®) - siRNA To receive the in-network level of benefits, you must use a provider who participates in our GCIT Designated Network. Note: Prior approval is required. Call us at 800-638-8432 prior to scheduling. See Section 3, *Other services*. Note: See Section 5(a), *Treatment therapies* for services provided by a physician. Note: The Plan has special arrangements with facilities to provide services and supplies related to GCIT and may provide travel assistance, see Section 5 (h), *Wellness and Other Special Features*, GCIT Designated Network. For additional information regarding the GCIT Designated Network, please call 800-638-8432.	GCIT Designated Network: 15% of the Plan allowance Out-of-network: No benefit
Not covered: • *Outpatient hospital services/supplies for surgery we do not cover except as noted above.*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Extended care benefits/Skilled nursing care facility benefits	**High Option**
We cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 60 days per calendar year when: • The stay is medically necessary • The stay is supervised by a physician Note: If Medicare pays first for your care, the first 20 days of your stay (paid in full by Medicare) do not count toward the 60-day benefit limit each calendar year. Note: Skilled Nursing Facility admissions require precertification; failure to do so will result in a minimum $500 penalty.	In-network: $200 copayment for each admission and all charges in excess of the 60-day maximum (No deductible) Out-of-network: $400 copayment for each admission, 30% of the covered charges and all charges in excess of the 60-day maximum and the difference between the Plan allowance and the billed amount (No deductible)
Not covered: • *Custodial care*	*All charges*
Hospice care	**High Option**
Hospice is a coordinated program of maintenance and supportive care designed to provide palliative and supportive care to members with a projected life expectancy of six (6) months or less due to a terminal medical condition, as certified by the member's physician or specialist and provided by a medically supervised team under the direction of a Plan approved independent hospice administration. Note: This benefit does not apply to services covered under any other benefit of the Plan. Note: See Section 5(h), *Wellness and Other Special Features, Care Management Program* for more information on advance care planning	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Private duty nursing* • *Custodial care* • *Homemaker services* • *Home hospice care (e.g., care given by a home health aide) that is provided and billed for by other than the approved home agency when the same type of care is already being provided by the home hospice agency*	*All charges*

Benefits Description	You pay After the calendar year deductible...
Ambulance	**High Option**
• Professional ambulance service to the nearest facility equipped to handle the patient's condition, including air ambulance when medically necessary Note: We also cover medically necessary emergency care provided at the scene when transport services are not required. Note: See Section 5(d) for *emergency ambulance service*.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Ambulance transportation for your own or your family's convenience* • *Transportation to other than a hospital, skilled nursing facility, dialysis, hospice or urgent care medical facility* • *Ambulance and any other modes of transportation to or from services including, but not limited to, physician appointments, or diagnostic tests, except as part of covered inpatient hospital care*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: **In-network:** $350 for Self Only; $700 for Self Plus One and Self and Family. **Out-of-network:** $800 for Self Only; $1,600 for Self Plus One and Self and Family. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use a network provider. When no network provider is available, out-of-network benefits apply.
- When you use an in-network facility, keep in mind that the healthcare professionals who provide services to you in the facility may not be in-network providers. We will pay up to the Plan allowance at the in-network provider percentage for services you receive from out-of-network anesthesiologists (including Certified Registered Nurse Anesthetists), radiologists, pathologists, emergency room physicians, hospitalists, intensivists, neonatologists, and surgeons when immediate or emergency care is required. You will be responsible to pay the in-network coinsurance and any difference between the Plan allowance and billed amount for these out-of-network providers.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your PSHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of $100 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

What is an accidental injury?

An accidental injury is a bodily injury that requires immediate medical attention and is sustained solely through violent, external, and accidental means, such as broken bones, animal bites, insect bites and stings and poisonings. An accidental dental injury is covered under Section 5(g), *Dental benefits*.

What is a medical emergency?

A medical emergency is 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 or surgical care. Medical emergencies include heart attacks, cardiovascular accidents, loss of consciousness or respiration, convulsions, and such other acute conditions that we determine to be medical emergencies.

Benefits Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	**High Option**
If you or a family member is accidentally injured, the Plan will pay up to the Plan allowance for: • Covered services and supplies provided in an initial emergency room facility visit for an accidental injury; or • Covered services and supplies provided in an initial urgent care center visit for an accidental injury; or • Covered services and supplies provided during the initial visit to a physician's office for an accidental injury, including related services outside the physician's office. Services must be provided the same day as the initial office visit. We pay for services performed after the initial visit, such as x-rays, laboratory tests, drugs, or any supplies or other services under Section 5(a); • Series of Rabies vaccinations Note: Regular Plan benefits apply after the initial ER, urgent care, physician, or other healthcare professional office visit. Note: We pay for services performed outside the ER or urgent care facility under the appropriate Plan benefit. Note: We pay hospital benefits as specified in Section 5(c), *Services provided by a hospital or other facility* if you are admitted to the hospital.	In-network: Nothing (No deductible) Out-of-network: The difference between the Plan allowance and the billed amount (No deductible)
Medical emergency	**High Option**
Plan benefits are paid for care you receive because of a medical emergency (non-accident) like a heart attack or stroke, including anesthesia. Note: Regular Plan benefits apply after initial ER, physician's, or other healthcare professional's office visit. Note: We pay emergency room fees billed by the hospital as Inpatient hospital benefits as specified in Section 5(c), *Inpatient hospital* if you are admitted as an inpatient through the emergency room.	In-network: • **Services in a primary care provider's office -** $20 copayment (No deductible) • **Services in a specialist provider's office** - $35 copayment (No deductible) • **Services outside the primary care provider's or specialist provider's office** — $200 copayment (No deductible) Out-of-network: • **Services provided in a primary care provider or specialist provider's office -** 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible) • **Services outside the primary care provider's or specialist provider's office** — $200 copayment and any difference between our allowance and the billed amount (No deductible)
Services you receive for your medical emergency in an urgent care center.	In-network: $35 copayment per occurrence (No deductible)

Medical emergency - continued on next page

Benefits Description	You pay After the calendar year deductible…
Medical emergency (cont.)	**High Option**
Note: We pay medical supplies, medical equipment, prosthetic and orthopedic devices for use at home under Section 5(a), *Medical services and supplies.* Note: Non-urgent care services received in an urgent care center are paid under Section 5(a), *Diagnostic and treatment services.*	In-network: $35 copayment per occurrence (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Ambulance	**High Option**
• Professional ambulance service to the nearest facility equipped to handle the patient's condition, including air ambulance when medically necessary. Note: We also cover medically necessary emergency care provided at the scene when transport services are not required. Note: See 5(c) for non-emergency service.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)
Not covered: • *Ambulance transport for your own or your family's convenience* • *Transportation to other than a hospital, skilled nursing facility, dialysis, hospice or urgent care medical facility*	*All charges*

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient copayment applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. The calendar year deductible is: **In-network**: $350 for Self Only; $700 for Self Plus One and Self and Family. **Out-of-network:** $800 for Self Only; $1,600 for Self Plus One and Self and Family.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also, read Section 9 for information about how we pay if you have other coverage, including Medicare, or if you are age 65 or over.
- **YOU MUST GET PRECERTIFICATION OR PRIOR APPROVAL FOR:**
  - Inpatient admissions
  - Residential treatment center (RTC) admissions
  - Transcranial Magnetic Stimulation (TBS)
  - Applied Behavior Analysis (ABA)

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

- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your PSHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of $100 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

Benefits Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional services	**High Option**
We cover professional services, including telehealth consultations by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Psychiatric office visits to a behavioral health practitioner • Substance Use Disorder (SUD), including detoxification, treatment and counseling • Behavioral therapy • Telehealth consultations Note: Telehealth consultations are covered when your provider uses a Health Insurance Portability and Accountability Act (HIPAA) compliant tool for facilitating telehealth consultations.	In-network: $20 copayment (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Applied Behavioral Analysis (ABA) The Plan covers medically necessary applied behavioral analysis therapy including the assessment only when provided by behavioral health providers. These providers include: • Providers who are licensed or who possess a state-issued or state sanctioned certification in ABA therapy. • Behavior analyst certified by the Behavior Analyst Certification Board (BACB) • Registered Behavior Technicians (RBTs) certified by the BACB or equivalent paraprofessionals who work under the supervision of a licensed provider or a certified behavior analyst. Note: Assessment and treatment for ABA requires prior approval. See Section 3, *How you get care* for information on how to precertify and obtain prior approval for your care.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Skilled behavioral health services provided in the home, but only when all of the following criteria are met: • You are homebound • Your physician orders the services • The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home • The skilled behavioral healthcare is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount

Professional services - continued on next page

Benefits Description	You pay After the calendar year deductible…
Professional services (cont.)	**High Option**
Telehealth consultations are available to members in the 50 United States through Teladoc® such as: • Doctors of Medicine (MD) • Doctors of Osteopathic Medicine (DO) • Licensed Clinical Social Workers (LCSW) • Psychiatrists • Psychologists See www. teladoc.com/Aetna or call 855-835-2362 (855-Teladoc) for information regarding consults. See Section 5(h), *Wellness and Other Special Features* for additional information.	In-network: Nothing (No deductible) Out-of-network: No benefit
Diagnostics	**High Option**
• Psychological testing provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	In-network: 15% of the Plan allowance Out-of-network: 30% of the Plan allowance any difference between our allowance and the billed amount
Physical, occupational and speech therapies	**High Option**
Outpatient physical, occupational, and speech therapy visits for the diagnosis of autism and developmental delays.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility, including an overnight residential treatment facility (RTC) Note: RTC benefits are not available for facilities licensed as a skilled nursing facility, group home, therapeutic boarding school, halfway house, or similar type facility. Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, then we will consider the private room rate. Note: Benefits are not available for non-covered services, including but not limited to: respite care; outdoor residential programs; services provided outside of the provider's scope of practice; recreational therapy; educational therapy; educational classes; bio-feedback; Outward Bound programs; equine therapy provided during the approved stay; personal comfort items, such as guest meals and beds, phone, television, beauty and barber services; custodial or long term care ; and domiciliary care provided because care in the home is not available or is unsuitable.	In-network: $200 copayment for each hospital admission (No deductible) Out-of-network: 30% of the covered charges (No deductible)

Benefits Description	You pay After the calendar year deductible…
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility All other outpatient mental health treatment including: • Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a physician • Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a physician • Outpatient detoxification • Ambulatory detoxification which is outpatient services that monitor withdrawal from alcohol or other substance abuse, including administration of medications • Treatment of withdrawal symptoms • Electro-convulsive therapy (ECT) • Mental health injectables • Substance abuse injectables • Transcranial magnetic stimulation • Observation less than 24 hours Note: Partial hospitalization programs must be licensed to provide mental health and/or substance use disorder treatment. Services must be at least four hours per day and may include group, individual, and family therapy along with psychoeducational services and adjunctive medication management. Note: Intensive outpatient programs must be licensed to provide mental health and/or substance use disorder treatment. Services must be provided for at least two hours per day and may include group, individual, and family therapy along with psychoeducational services and adjunctive psychiatric medication management.	In-network: 15% of the Plan allowance (No deductible) Out-of-network: 30% of the Plan allowance and any difference between our allowance and the billed amount
Outpatient observation care 24 hours or more performed and billed by a hospital or freestanding ambulatory facility Note: All outpatient services billed by the facility during the time you are receiving observation services are included in the cost-share amounts shown here. See Section 5(a) for *services billed by professional providers* during an observation stay.	In-network: $200 copayment for each hospital admission (No deductible) Out-of-network: 30% of the covered charges (No deductible)
Not covered	**High Option**
• *Services we have not approved* • *All charges (including room and board) for chemical aversion therapy, conditioned reflex treatments, narcotherapy, and similar aversion treatments* • *Counseling or therapy for educational or learning disorders* • *Community based programs such as self-help groups or 12-step programs*	*All charges*

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in this section.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal or state laws prevent the pharmacy from accepting unused drugs or supplies.
- The calendar year prescription drug deductible is: $200 per person. The prescription drug deductible of $200 does not apply to members who have Medicare A and B as primary coverage. This is a separate deductible from the Plan's calendar year deductible and applies to prescription drugs that you buy at any network or non-network retail drugstore or pharmacy. The prescription drug deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the prescription drug deductible does not apply.
  - Note: Deductible does not apply to prescriptions if you are enrolled in our SilverScript Employer Prescription Drug Plan (PDP) for Rural Carrier Benefit Plan PSHB, see Section 9, *Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP).*
- The Out-of-network benefits are the standard benefits of this Plan. In-network benefits apply only when you use a network provider. When no network provider is available, out-of-network benefits apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost sharing works. Also, read Section 9 for information about how we pay if you have other coverage, or if you are age 65 or over.
- A PDP EGWP covers prescription drugs only, whereas an MAPD EGWP includes prescription drug, physician, and hospital coverage. Enrollees should review the options available under the Plan to determine which best meets their needs, as PDP EGWP and MAPD EGWP plans may differ in coverage and drug cost-sharing.
- If you are covered by Medicare and Medicare Part A or B or Parts A and B is primary and you are not enrolled in our Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan members, we will automatically enroll you in our SilverScript Employer Prescription Drug Plan (PDP) for Rural Carrier Benefit Plan. This Medicare Part D Plan enhances your PSHB coverage by offering lower cost sharing on covered drugs. You can find more details about this Plan and the opt out process in Section 9, *Medicare Prescription Drug Plan Employer Group Waiver Plan (PDP EGWP).* The PDP is subject to Medicare rules.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of $100 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.
- **The exclusion for hormone treatments for Sex-Trait Modification for gender dysphoria** only pertains to chemical and surgical modification of an individual's sex traits (including as part of "gender transition" services). **We do not exclude coverage for entire classes of pharmaceuticals,** e. g., GnRH agonists may be prescribed during IVF, for reduction of endometriosis or fibroids, and for cancer treatment or prostate cancer/tumor growth prevention.

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

Who can write your prescription? A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication.

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

- CVS Health participating (In-network) pharmacy: You may fill your prescription at any CVS Health participating pharmacy. To find a participating pharmacy near where you live, call CVS Health toll-free at 800-292-4182 or on the Internet at www. Caremark.com or through a link on our website at www. RCBPhealth.com. You must show the pharmacy your Plan ID card (that includes the CVS Health logo) to receive the negotiated discount price. You pay the coinsurance and any deductible, if applicable, for your prescription. You do not need to file a claim when you use a CVS Health participating pharmacy and show your Plan ID card. The participating pharmacy will file the claim with CVS Health for you. Prescriptions you purchase at a CVS Health network pharmacy without using your ID card are at the full regular price charged by the pharmacy. If you do not show your ID card at a participating pharmacy, you will need to file a claim with CVS Health.
- Non-participating (Out-of-network) pharmacy: You may fill your prescription at any out-of-network pharmacy. You pay the full regular price for your prescription and then file a claim with CVS Health.
- CVS Caremark mail service pharmacy: You may fill your long-term prescription through the CVS Caremark mail service pharmacy. You will receive order forms and information on how to use the mail service prescription program from CVS Caremark . To order your prescription by mail: 1) complete the CVS Caremark order form; 2) enclose your prescription(s) and copayment(s); 3) mail your order to CVS Caremark, P O Box 659572, San Antonio, TX 78256-9572; and 4) allow approximately two weeks for delivery. You will receive order forms for refills and future prescription orders each time you use the mail service program. You can also order refills from the mail service program by phone toll-free at 800-292-4182 or on the Internet at www. Caremark.com.

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

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

Please see our online formulary and drug pricing search tools at www. RCBPhealth.com, or call us at 800-638-8432 for assistance.

CVS Caremark's Primary/Preferred Drug list

The CVS Caremark Primary/Preferred Drug list is a list of “preferred” prescription drugs that are identified by the CVS Health team of physicians and pharmacists (Pharmacy and Therapeutics Committee) to be the best overall value based on quality, safety, effectiveness, and cost. The Primary/Preferred Drug list includes nearly all covered generic drugs, and specific brand name drugs. We list the most commonly requested formulary drugs on the Primary/Preferred Drug list. To order a Primary/ Preferred Drug list, call the CVS Health Customer Service Department at 800-292-4182 or visit our website at www. RCBPhealth.com/prescription-benefits/.

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

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

Prior Authorization: We require prior authorization for certain drugs, such as specialty, weight management and nonpreferred (non-formulary) medications. To obtain a list of drugs that require prior authorization, please call the CVS Health Customer Service Department at 800-292-4182. The prior authorization drug list is reviewed by the CVS Health Pharmacy and Therapeutics Committee and may change from time to time due to new drugs, new generic drugs, new therapies, new guidelines from the FDA, or other factors. For those drugs that require prior authorization, you should discuss with your physician or pharmacist about available options that do not require prior authorization. To request prior authorization, your physician may contact the CVS Health Prior Authorization Department at 855-240-0536. CVS Health will work with your physician to obtain the information we need to process the request. You may contact the CVS Health Customer Service Department for the status of your request at 800-292-4182.

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

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

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

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

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

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

Site of Care Management for Specialty Medications

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

These are the dispensing limitations.

- You may purchase up to a 34-day supply of medication at any network retail pharmacy. There is a limit of the number of refills that you can buy at a network retail pharmacy for long-term maintenance medications (prescription medications that you take every day). You can buy an initial 34-day supply and two refills for long-term medications at a network retail pharmacy during any twelve month period. After the third fill at a network retail pharmacy, you must purchase your long term medications through the CVS Caremark mail service pharmacy or a CVS Pharmacy to have the prescriptions covered by the Plan.

- There is also a 34-day supply limit for prescriptions that you buy at a non-participating pharmacy. In addition, you are limited to an initial 34-day supply plus two refills for long-term maintenance medications that you buy at a non-participating pharmacy. You pay the full regular price for any prescription that you buy at a non-participating pharmacy and then file a claim with CVS Caremark for reimbursement after you satisfy the annual $200 prescription drug deductible, if applicable.
- A generic equivalent will be dispensed if it is available. If you receive a prescription for a brand name drug when a FDA approved generic drug is available, even if your physician requests "Dispense as Written" (DAW) on the prescription, you have to pay the difference in cost between the brand name drug and its generic equivalent plus the generic (Tier 1) copayment.
- You may purchase up to a 90-day supply of a medication through the CVS Caremark mail service prescription program. If you request a refill before you use 75% of the medication or 80% for controlled medications, CVS Caremark will return the refill request to you. CVS Caremark follows generally accepted pharmacy standards when filling your prescriptions. These include Federal and state pharmacy regulations, the professional judgment of the pharmacist, and the usage recommendations of the drug manufacturer as approved by the U.S. FDA. If a FDA approved generic drug is available, CVS Caremark will substitute for a brand name drug. Certain types of prescription medications are not available through the mail service program such as:
  - Specially mixed (compounded) capsules and suppositories
  - Vaccines
  - Frozen medications
  - Dental products
  - Most medical devices
  - Infertility drugs
  - Medications specially wrapped in unit dose packaging

Note: Always request a generic drug from your physician or other prescriber when a generic is available. If a generic equivalent is available, but the pharmacy dispenses the brand name medication, you will pay the difference in cost between the brand name medication and the generic medication plus the generic (Tier 1) copayment. Similarly if your physician or other prescriber indicates "dispense as written" on the prescription, you will pay the difference in cost between the brand name medication and the generic medication plus the generic (Tier I) copayment.

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

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

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

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

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

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

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

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

Claims for prescription drugs and supplies that are not ordered through the CVS Caremark mail service prescription program or a CVS Caremark In-network pharmacy must include receipts that have the patient's name, the prescription number, name of the drug, day supply, the medication's National Drug Code (NDC), prescribing physician's National Provider Identifiers (NPI), date, charge, and pharmacy name. The pharmacist must sign any computer printout or pharmacy ledger. Prescription claim forms are available by calling toll-free 800-292-4182 or at our website at www. RCBPhealth.com.

Benefits Description	You pay After the calendar year deductible…
The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	**High Option**
When you enroll in the Plan, you will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail service order form/patient profile and a preaddressed reply envelope for the mail service prescription program. You may purchase the following medications and supplies prescribed by a physician from either a retail pharmacy or through the CVS Caremark mail service pharmacy: • Drugs and medications (including those administered during a non-covered admission or in a non-covered facility) that require a physician's written prescription under U.S. Federal law, except those listed as Not covered • Vitamins and minerals that require a physician's prescription for purchase under U.S. Federal law • Insulin • Disposable needles and syringes for the administration of covered medications • Fertility drugs – three (3) cycles or more Note: Certain drugs to treat infertility are considered Specialty drugs, see *Specialty drugs* section.	In-network Retail, up to a 34-day supply: • Tier 1: 30% of cost; maximum $7.50 per prescription • Tier II: 30% of cost; maximum $200 per prescription • Tier III: 30% of cost; maximum $200 per prescription Out-of-network Retail: 30% of cost CVS Retail Pharmacy or CVS Caremark mail service, up to 90-day supply: • Tier I: $10 generic (No deductible) • Tier II: $50 brand name on primary drug list (No deductible) • Tier III: $80 brand name not on primary drug list (No deductible)

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**High Option**
• Tobacco cessation drugs and medications. See also E*ducational classes and programs* in Section 5 (a), *Medical services and supplies* for information about the Plan's Tobacco Cessation Program • Prescription drugs for weight management Note: Prescription drugs for weight management require prior authorization. To obtain weight loss drugs, you must enroll in the Telephonic Health Coaching Program for Weight Management. For additional program information, see Section 5(h), *Wellness and Other Special Features* under T*elephonic Health Coaching for Weight Management*. • Medical foods, as defined by the U.S. Food and Drug Administration, that are consumed or administered enterally and are intended for the specific dietary management of a disease or condition for which there are distinctive nutritional requirements. Note: The Plan covers medical food formulas and enteral nutrition products that are ordered by a healthcare provider and are medically necessary to prevent clinical deterioration in members at nutritional risk. (See Coverage below) Must meet the definition of medical food (see *Definitions*, Section 10,) Note: You must be receiving active, regular, and ongoing medical supervision and must be unable to manage the condition by modification of diet alone. Coverage is provided as follows: • Inborn errors of amino acid metabolism • Food allergy with atopic dermatitis, gastrointestinal symptoms, IgE mediation, malabsorption disorder, seizure disorder, failure to thrive, or prematurity, when administered orally and is the sole source (100%) of nutrition. This once per lifetime benefit is limited to one year following the date of the initial prescription or physician order for the medical food (e.g., Neocate, in a formula form or powders mixed to become formulas) Note: A prescription is required for medical foods provided under the pharmacy benefit. Note: Colostomy and ostomy supplies are covered under Section 5(a), *Durable medical equipment*. Note: A blood glucose meter can be provided at no charge. For more information on how to obtain a blood glucose meter, call toll-free: 800-588-4456.	In-network Retail, up to a 34-day supply: • Tier 1: 30% of cost; maximum $7.50 per prescription • Tier II: 30% of cost; maximum $200 per prescription • Tier III: 30% of cost; maximum $200 per prescription Out-of-network Retail: 30% of cost CVS Retail Pharmacy or CVS Caremark mail service, up to 90-day supply: • Tier I: $10 generic (No deductible) • Tier II: $50 brand name on primary drug list (No deductible) • Tier III: $80 brand name not on primary drug list (No deductible)

Covered medications and supplies - continued on next page

Benefits Description	You pay After the calendar year deductible…
Covered medications and supplies (cont.)	**High Option**
Note: For long-term maintenance medications, you are limited to the initial prescription and two refills at a CVS In-network retail pharmacy or at an out-of-network retail pharmacy. You must use the CVS Caremark mail service pharmacy or a CVS Pharmacy for a continuing supply of the medication after three fills.	In-network Retail, up to a 34-day supply: • Tier 1: 30% of cost; maximum $7.50 per prescription • Tier II: 30% of cost; maximum $200 per prescription • Tier III: 30% of cost; maximum $200 per prescription Out-of-network Retail: 30% of cost CVS Retail Pharmacy or CVS Caremark mail service, up to 90-day supply: • Tier I: $10 generic (No deductible) • Tier II: $50 brand name on primary drug list (No deductible) • Tier III: $80 brand name not on primary drug list (No deductible)
Diabetic supplies such as test strips and lancets	Nothing (No deductible)
Specialty drugs are used to treat chronic complex conditions and require special handling and close monitoring and must be obtained from CVS Specialty Pharmacy. Note: Preauthorization is required. Call CVS Specialty Pharmacy at 866-814-5506 for more information	CVS Caremark Specialty Pharmacy, up to 30-day supply: • Tier IV: $70 Specialty generic drugs (No deductible) • Tier V: $90 Specialty preferred brand drugs (No deductible) • Tier VI: $120 Specialty non-preferred brand drugs (No deductible) CVS Caremark Specialty Pharmacy, up to 90-day supply: • Tier IV: $100 Specialty generic drugs (No deductible) • Tier V: $125 Specialty preferred brand drugs (No deductible) • Tier VI: $250 Specialty non-preferred brand drugs (No deductible)
Over-the-counter (OTC) nicotine replacement therapy or prescription drugs approved by the FDA to treat and nicotine dependence. A doctor's written prescription is required. See also *Educational classes and programs* in Section 5(a), *Medical services and supplies* for information about the Plan's Tobacco Cessation Program.	In-Network Retail: Nothing (No deductible) Out-of-network Retail: Nothing (No deductible) CVS Caremark mail service: Nothing (No deductible)
Preventive medications	**High Option**
• Preventive medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-a-and-b-recommendations. • CVS Caremark ACA No-Cost Preventive Services List. A complete list is available online at www.caremark.com	In-network Retail: Nothing Out-of-network Retail: All Charges

Preventive medications - continued on next page

Benefits Description	You pay After the calendar year deductible…
Preventive medications (cont.)	**High Option**
Drugs and supplements on the lists are covered even if they are listed as over-the-counter. Your doctor must write a prescription for these preventive services and they must be filled at a network pharmacy.	In-network Retail: Nothing Out-of-network Retail: All Charges
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at https://www.fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www. findtreatment.samhsa.gov/.	In-network Retail: Nothing (No deductible) Out-of-network Retail: Nothing (No deductible) CVS Caremark mail service: Nothing (No deductible)
Contraceptive drugs and devices as listed in the Health Resources and Services Administration site https :// www. hrsa.gov/womens-guidelines. Coverage includes: • Oral Contraceptives • Emergency Contraceptives • Injectable Contraceptives • Miscellaneous Contraceptives —Intrauterine Devices (IUD), Subdermal Rods & Vaginal Rings • Contraceptive transdermal patches • Barrier Methods- Cervical Caps and Diaphragms • Over-the-counter (OTC) Contraceptives (requires prescription) • Vaginal pH Modulators Contraceptive coverage is available at no cost to PSHB members. The contraceptive benefit includes at least one option in each of the HRSA-supported categories all methods of contraception (as well as the screening, education, counseling, and follow-up care). Any contraceptive that is not already available without cost sharing on the formulary can be accessed through the contraceptive exceptions process described below.	In-Network Retail: Nothing (No deductible) Out-of-network Retail: Nothing (No deductible) CVS Caremark mail service: Nothing (No deductible)

Preventive medications - continued on next page

Benefits Description	You pay After the calendar year deductible…
Preventive medications (cont.)	**High Option**
Visit www. rcbphealth.com/contraception-coverage/ or call us at 800-292-4182 for our contraceptive exception process or for information on our reimbursement for OTC contraceptives (prescription required). Once we have been contacted and have all the required information, we will process your contraceptive exception and you will receive a response within 24 hours or the next business day. Contraceptive exception requests are not subject to Section 8. The Disputed Claims Process. If you have difficulty accessing contraceptive coverage or other reproductive healthcare, you can contact contraception@opm.gov	In-Network Retail: Nothing (No deductible) Out-of-network Retail: Nothing (No deductible) CVS Caremark mail service: Nothing (No deductible)
Not covered	**High Option**
• *Drugs and supplies for cosmetic purposes* • *Drugs to treat impotence and sexual dysfunction* • *Medical foods and nutritional supplements, except as described in Section 5(a), Durable medical equipment and Section 5(f), Covered medications.* • *Nonprescription (over-the-counter) medications, except as noted above*	*All charges*

Section 5(f)(a). PDP EGWP Prescription Drug Benefits

Important things you should keep in mind about these benefits:

- If you are not enrolled in our Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan and have Medicare Part A and/or B primary, we will automatically enroll you in our SilverScript Employer Prescription Drug Plan (PDP). These prescription drug benefits are for members enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP). The PDP EGWP is subject to Medicare rules.
- If you are a Postal Service annuitant and their covered Medicare-eligible family member, you will be automatically group enrolled in our PDP EGWP. Contact us for additional information at 833-825-6754.

Note: Notify us as soon as possible if you or your eligible family member is already enrolled in a Medicare Part D Plan. Enrollment in our PDP EGWP will cancel your enrollment in another Medicare Part D plan.

There are advantages to being enrolled in our PDP EGWP:

- In our PDP EGWP, your cost-share for covered drugs, medications, and supplies will be equal to or better than the cost-share for those enrolled in our standard non-PDP EGWP Prescription Drug Program.
- In our PDP EGWP, you have access to a pharmacy network including retail, mail-order, long term care and home infusion pharmacies.
- PDP EGWP Catastrophic Protection Out-of-Pocket Maximum is $2,000 per person After you reach your individual maximum out-of-pocket costs of $2,000, we will pay 100% of all eligible covered prescription drugs.

We cover drugs, medications, and supplies as described in this section.

- Please remember that all benefits are subject to the definitions, limitations and exclusions in the Evidence of Coverage and this brochure and are payable only when we determine they are medically necessary.
- Your prescribers must obtain prior authorization for certain prescription drugs. Prior authorizations must be renewed periodically. For more information about the prior authorization process, please call us at 800-638-8432 or visit our website at www. RCBPhealth.com.
- Federal or state laws may prevent the pharmacy from accepting unused drugs.
- There is no calendar year deductible for prescription drugs.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works.
- Participants who are enrolled in our SilverScript PDP EGWP will receive a separate prescription ID card to use for filling prescriptions.
- Be sure to read Section 9 about how we pay if you have other coverage.
- Those with higher incomes may have a separate premium payment for your PDP EGWP benefit. Please refer to the Part D-Income Related Monthly Adjustment Amount (IRMAA) section of Medicare website: www. medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans to see if you would be subject to an additional premium.
- If you choose to opt out of or disenroll from our PDP EGWP, see Section 9 for additional PDP EGWP information and for our opt-out and disenrollment process. Contact us for assistance with the PDP EGWP opt out and disenrollment process at 833-825-6754.

Warning: If you opt out of or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note: If you choose to opt of or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll during Open Season or if you have a qualifying life event (QLE). If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 833-825-6754.

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

Who can write your prescription. A licensed physician or dentist, and in the states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice, must prescribe your medication. Your prescribers must have Medicare-approved prescriptive authority.

Where you can obtain them. You may fill the prescription at a network retail pharmacy or by network mail-order pharmacy for certain drugs. In an emergency, you may fill prescriptions up to a 30-day supply at an out-of-network pharmacy but will be required to submit a claim for reimbursement. For assistance locating a PDP EGWP network pharmacy, visit our website at www. RCBPhealth.com, or call us at 833-825-6754.

We have a formulary. A formulary is a list of covered drugs selected by SilverScript in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. SilverScript will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a SilverScript network pharmacy, and other plan rules are followed. For more information or to see our online formulary and drug pricing search tools visit our website at www. RCBPhealth.com or call us at 833-825-6754.

These are the dispensing limitations. Some covered drugs may have additional requirements or limits on coverage. Also, in most cases, refills cannot be obtained until 75% of the drug has been used. Occasionally, as part of regular review, we may recommend that the use of a drug is appropriate only with limits on its quantity, total dose, duration of therapy, age, sex or specific diagnoses. Since the prescription does not usually explain the reason your provider prescribed a medication, we may implement any of these limits and/or require prior authorization confirm the intent of the prescriber.

- **Prior Authorization (PA)**: Some drugs require you or your physician to get prior authorization. You must get an approval from us before you can get your prescription filled. If you don't get approval, we may not cover the drug.
- **Quantity Limits (QL)**: For certain drugs, there is a quantity limit in the amount of the drug that we will cover. For example, our plan provides up to 30 tablets per 30-day prescription for atorvastatin. This may be in addition to a standard one-month or three month supply.
- **Step Therapy (ST)**: In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, SilverScript will then cover Drug B.

You may request a Formulary Exception. Asking for coverage of a drug that is not on the formulary is sometimes called a formulary exception. Asking for removal of a restriction on coverage for a drug is sometimes called a formulary exception. Asking to pay a lower price for a covered non-preferred drug is sometimes called a **tiering exception**.

Start by calling, writing, or faxing SilverScript to make your request for us to authorize or provide coverage for the prescription you want. You can also access the coverage decision process through caremark.com website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form. You, your doctor, (or other prescriber), or your representative can request an exception.

A generic equivalent will be dispensed if it is available unless your physician specifically requires a brand name drug.

Why use generic drugs? A generic drug is the chemical equivalent to a brand name drug, yet it costs much less. Choosing generic drugs rather than brand name drugs can reduce your out-of-pocket expenses. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand name drugs. They must contain the same active ingredients, be equivalent in strength and dosage, and meet the same standards for safety, purity and effectiveness as the original brand name product.

When you do have to file a claim. Members who purchase prescriptions at a non-network pharmacy, mail your SilverScript claim form and prescription receipts to:. SilverScript Insurance Company, Prescription Drug Plans, Medicare Part D Paper Claim, P.O. Box 52066, Phoenix, AZ 85072-2066. Receipts must include the prescription number, name of drug, date, prescribing doctor's name, charge, name and address of pharmacy and NDC number (included on the bill). See Section 7, How to claim benefits for additional information.

If we deny your prescription drug claim and you want to appeal, you, your representative, or your prescriber must request an appeal following the process described in Section 8(a), *The Medicare Part D PDP EGWP Plan Sponsored Disputed Claims Process.*

Benefits for all prescription drugs will be determined based on the fill date for the prescription.

PDP EGWP Catastrophic Maximum. Our PDP EGWP Catastrophic Out-of-Pocket Maximum is $2,000. After you reach your individual maximum out-of-pocket costs of $2,000, we will pay 100% of all eligible covered prescription drugs.

Benefits Description	You pay
Note: THE CALENDAR YEAR DEDUCTIBLE DOES NOT APPLY TO BENEFITS IN THIS SECTION.	
Covered medications and supplies	**High Option**
You may purchase the following medications and supplies prescribed by a physician from either a Network retail pharmacy or our network mail order pharmacy (for certain prescription drugs): • Drugs and medications that by Federal law of the United States require a doctor's written prescription Note: This prescription drug plan offers a formulary which covers Part D drugs required by CMS and additional drug coverage as outlined below • Non-Part D Supplemental Benefit including but not limited to: - Agents when used for the symptomatic relief of cough and colds. - Agents when used for weight loss - Prescription vitamins and mineral products - Medical foods, as defined by the U.S. Food and Drug Administration, that are consumed for administered enterally and are intended for the specific dietary management of a disease or condition for which there are distinctive nutritional requirements. A prescription is required for coverage under the pharmacy benefit. Note: For access to our formulary, please visit www.RCBPhealth.com Note: Prior authorization may be required for certain drugs, call us at 1-800-294-5979 if you have any questions regarding prior authorization, quantity limits, or other issues.	In-network retail pharmacy, up to a 34-day supply: • Tier 1 (generic): $5 copayment • Tier II (preferred brand): $40 copayment • Tier III (non-preferred brand): $50 copayment In-network Retail Pharmacy or mail order, up to 90-day supply: • Tier I (generic): $10 copayment • Tier II (preferred brand): $40 copayment • Tier III: $70 copayment
Diabetic supplies such as test strips and lancets	In-network retail pharmacy or mail order, up to 90-day supply: Nothing
Specialty drugs are used to treat chronic complex conditions and require special handling and close monitoring.	In-network retail pharmacy, up to 30-day supply: • Tier IV (specialty): $70 copayment

Covered medications and supplies - continued on next page

Benefits Description	You pay
Covered medications and supplies (cont.)	**High Option**
Note: Prior authorization is required. Call us at 833-825-6754 if you have any questions regarding prior authorization, quantity limits, or other issues. We can help you understand the prior authorization process, the kinds of drugs that are considered to be specialty drugs, the kinds of medical conditions they are used for, and other questions you may have. Also, see the description of specialty drugs in this Section.	In-network retail pharmacy, up to 30-day supply: • Tier IV (specialty): $70 copayment In-network retail pharmacy, up to 90-day supply: • Tier IV (specialty): $100 copayment
Preventive medications	**High Option**
The following are covered: • Preventive Medications with USPSTF A and B recommendations. These may include some over-the-counter vitamins, nicotine replacement medications, and low dose aspirin for certain patients. For current recommendations go to www.uspreventiveservicestaskforce.org/BrowseRec/Index/browse-recommendations • SilverScript offers a ACA No-Cost Preventive Services list. A complete list is available online at www. caremark.com Note: Your doctor must write a prescription for these preventive services to be covered by the plan, even if they are listed as over-the-counter. Changes can occur throughout the year.	In-network retail pharmacy: Nothing
Opioid rescue agents are covered under this Plan with no cost sharing when obtained with a prescription from a pharmacy in any over-the-counter or prescription form available such as nasal sprays and intramuscular injections. For more information consult the FDA guidance at: https ://www. fda.gov/consumers/consumer-updates/access-naloxone-can-save-life-during-opioid-overdose Or call SAMHSA's National Helpline 1-800-662-HELP (4357) or go to www. findtreatment.samhsa.gov/	In-network retail pharmacy: Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs obtained at a non-network pharmacy; except for out-of-area emergencies or otherwise documented in our Evidence of Coverage document.* • *Over-the-counter medications even if prescribed by a physician, unless otherwise stated in this section* • *Nonprescription medications unless specifically indicated elsewhere*	*All charges*

Preventive medications - continued on next page

Benefits Description	You pay
Preventive medications (cont.)	**High Option**
• *Topical analgesics, including patches, lotions and creams* • *Erectile dysfunction drugs* • *Drugs obtained from a foreign pharmacy*	*All charges*

Section 5(g). Dental Benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your PSHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your PSHB Plan. See Section 9, *Coordinating benefits with other coverage*.
- The calendar year dental deductible is: $50 per person. The dental deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your Costs for Covered Services*, for valuable information about how cost-sharing works. Also, read Section 9 for information about how we pay if you other coverage, or if you are age 65 or over.
- Note: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We cover the dental procedure under Dental benefits listed below. See Section 5(c) for inpatient hospital benefits.
- If you enroll in Rural Carrier Benefit Plan and have primary Medicare Parts A and B, we offer Aetna Medicare Advantage for Rural Carrier Benefit Plan members. This Plan enhances your PSHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Rural Carrier Benefit Plan members who also enroll in the Aetna Medicare Advantage Plan for Rural Carrier Benefit Plan will receive a credit of $100 per month toward the cost of Medicare Part B. The Aetna Medicare Advantage Plan is subject to Medicare rules. See Section 9 for additional details.

Accidental Injury benefit	You Pay
Accidental Injury	**High Option**
The Plan will pay for the treatment or repair (including root canal therapy and crowns) of an accidental injury to sound natural teeth (not from biting or chewing). The services and supplies must be provided within one year of the accidental dental injury and the Patient must be a Plan member when the dental services are received. Note: We may request dental records, including X-rays, to verify the condition of your teeth before the accidental injury. Charges covered for dental accidents cannot be considered under Dental benefits.	In-network: 10% of Plan allowance (No deductible) Out-of-network: 20% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)

Dental Services	Plan Pays
Dental services	**High Option**
The Plan pays actual charges for up to two preventive care visits per person each calendar year up to the scheduled Plan allowance (No deductible).	Note: There is no network for the dental services listed below. You may receive services from any dental provider you choose. Note: You are responsible for all charges that exceed the Plan's scheduled allowance for the service listed below.
Oral exam	$12.50 twice each calendar year
Prophylaxis, adult and child	$22.00 twice each calendar year
Prophylaxis with fluoride treatment (thru age 22)	$24.00 twice each calendar year
Space maintainer	$88.00
Complete X-ray series	$34.00
Panoramic X-ray	$34.00
Single intraoral X-ray/bitewing single film	$5.50
Each additional intraoral X-ray (up to 7)	$4.00
Bitewings - 2 films	$9.00
Bitewings - 4 films	$14.00
After a deductible of $50 per person during the calendar year, the Plan pays actual charges up to the scheduled allowance for each service. There is no annual limit on the amount of services you receive	Note: There is no network for the dental services listed below. You may receive services from any dental provider you choose. Note: You are responsible for all charges that exceed the Plan's scheduled allowance for the service listed below.
Restorations - 1 surface permanent	$14.00
Restorations - 2 surface permanent	$20.50
Restorations - surface permanent	$26.50
Restorations - Gold restoration	$103.50
Extractions - Single tooth	$16.00
Extractions - Pulp capping-direct	$9.50
Extractions - Pulpotomy-vital	$21.00
Root canal therapy - One root This includes the actual root canal treatment and any replacements	$106.00
Root canal therapy - Two roots This includes the actual root canal treatment and any replacements	$126.00
Root canal therapy - Three or more roots This includes the actual root canal treatment and any replacements	$170.00
Periodontics - Periodontal scaling and root planning	$26.50
Crowns/abutments - Resin and Resin with metal	$120.00
Crowns/abutments - Porcelain	$113.50
Crowns/abutments - Porcelain with gold	$120.00
Crowns/abutments - Gold (full cast and 3/4 cast)	$120.00
Crowns/abutments - Prefabricated resin and stainless steel	$21.50
Pontics - Porcelain and Porcelain with gold	$120.00
Dentures - Complete upper and lower, each	$126.00
Dentures - Partial without bar	$138.00
Dentures - Partial with bar	$157.00
Dentures - Repairs (dentures and partials)	$14.00
Dentures - Denture relining	$40.50

Section 5(h). Wellness and Other Special Features

Special feature	Description
Flexible Benefits Option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the *OPM disputed claim process* (see Section 8).
Institutes of Excellence (IOE)	The Plan has special arrangements with facilities to provide services for tissue and organ transplants only. The transplant network was designed to give you the opportunity to access providers that demonstrate high quality medical care for transplant patients. Note: If a qualified tissue/organ transplant is medically necessary and performed at one of the Institutes of Excellence (IOE) network facilities, you may be eligible for reimbursement of some related expenses for travel and lodging for the transplant recipient and one family member or caregiver. We may also assist you and one family member or caregiver with travel and lodging arrangements. This benefit does not apply to normal in-network facilities but only to the IOE network facilities. Reimbursement is subject to IRS regulations. Note: Receipts are required for reimbursement of travel and lodging costs. You or your physician can coordinate arrangements by calling a case manager in Aetna's Medical Management Department at 800-638-8432. For additional information regarding the Aetna Transplant Network, please call toll-free 800-638-8432.
Gene-Based, Cellular and Other Innovative Therapies (GCIT) Designated Network	The Plan has special agreements with facilities to provide services and supplies related to GCIT™. The GCIT Designated Network was designed to provide high quality medical care for patients who have been diagnosed with certain genetic conditions. Note: If a qualified gene therapy service is medically necessary, performed at one of the GCIT facilities and the Plan is the primary payor, you may be eligible for reimbursement of some expenses for travel and lodging for the gene therapy recipient and one family member or caregiver. If the gene therapy recipient is 21 or younger, we may pay eligible travel costs for the patient and two caregivers. Reimbursement is subject to IRS regulations. Note: Receipts are required for reimbursement of travel and lodging costs.

	See Section 5(a), *Treatment therapies* and Section 5(c), *Outpatient hospital or ambulatory surgical center* for the Plan's gene therapy benefit. Contact the Plan at 800-638-8432 for more information. We are available to assist you Monday through Friday from 6:00 a.m. to 5:00 p.m. Mountain Standard Time (MST).
Cancer treatment benefit	We will pay 100% of the Plan allowance for drugs, services and supplies normally covered by the Plan for treatment of an illness diagnosed as cancer. The service or supply must be for the treatment of a malignancy. A diagnosis secondary to cancer is not covered under this benefit.
Kidney (renal) dialysis benefit	We will pay 90% of the Plan allowance for services, supplies and testing for kidney (renal) dialysis. This benefit applies to inpatient and outpatient kidney dialysis.
24-Hour Nurse Line	24-Hour Nurse Line provides eligible members with phone access to registered nurses experienced in providing information on a variety of health topics. 24-Hour Nurse Line is available 24 hours a day, 7 days a week and can be reached by calling 800-556-1555 . We provide TDD service for the hearing and speech-impaired. We also offer foreign language translation for non-English speaking members. 24-Hour nurses cannot diagnose, prescribe medication or give medical advice. Members also may e-mail a nurse by clicking on the "Talk to a Nurse" link on the Aetna member website at www.RCBPhealth.com. Nurses respond to these online member inquiries within 24 hours. The online Healthwise Knowledgebase is an online education support resource available to members through the Aetna member website. It is a user-friendly decision- support tool that provides clinical information on 6,000 health topics, 600 medical tests and procedures, 500 support groups and 3,000 medications. The tool promotes informed health decision-making and helps members learn about their treatment options. 24-Hour Nurse Line nurses also have access to the Healthwise video library and can relay video links to callers upon request or to provide further education/support of the health topic they discussed.
Healthy Maternity Program	You have access to Aetna's Healthy Maternity Program to support you on your maternity journey. Our Healthy Maternity Program provides trusted information and guidance about family planning, support and postpartum care. With this program, you will also have access to the following resources: • Nurses who are trained in obstetrics and high-risk pregnancy conditions. • Behavioral health support, including referrals to resources to deal with stress, depression, and anxiety • Postpartum depression screening and support • Resources and educational materials through our Maternity Support Program • Guided medically appropriate genetic counseling and testing • Preeclampsia prevention – If you are identified as high-risk, you will receive educational materials about preeclampsia risk factors, and the benefits of aspirin therapy. • Fertility advocate to help you throughout your infertility journey, fertility preservation, same-sex conception needs, and more. The advocate will also provide support and guidance during fertility treatment and provide support if you become pregnant. For direct access to a fertility advocate, call 833-415-1709.

	No matter where you are on your journey, our nurses and experts are here to support you along the way. Participation in this program is voluntary and available at no cost to you. The participant and their physician or healthcare provider remain in charge of the participant's treatment plan. If you would like more information or would like to enroll in the Healthy Pregnancy Program, contact the Plan at 855-282-6344.
Complex and Chronic Disease Management Program	AccordantCare offers programs for the following complex chronic medical conditions: • Seizure disorders (Epilepsy) • Rheumatoid Arthritis (RA) • Multiple Sclerosis (MS) • Crohn's Disease • Parkinson's Disease (PD) • Systemic Lupus Erythematosus (SLE) • Myasthenia Gravis (MG) • Sickle Cell Disease (SCD) • Cystic Fibrosis (CF) • Hemophilia • Scleroderma • Gaucher Disease • Polymyositis • Amyotrophic Lateral Sclerosis (ALS-Lou Gehrig's Disease) • Dermatomyositis • Chronic Inflammatory Demyelinating Polyradiculoneuropathy (CIDP) • Ulcerative Colitis • Human Immunodeficiency Virus (HIV) • Chronic Kidney Disease (CKD) • Pulmonary Arterial Hypertension (PAH) For more information on the AccordantCare programs, please call toll-free 866-380-6295
Care Management Program	For your health needs and concerns, RCBP offers several resources through our Care Management Program to assist you with your care coordination for acute and/or chronic condition(s). This program provides education, clinical support, and access to support and well-being tools to help you better manage your health. Our Care Management Program offers: • 1:1 support with a clinical nurse who can help you: - Assistance in developing a plan to address your specific health needs and achieve your goals - To help you understand your benefit offerings - To answer your health-related questions • Group Coaching • Digital support • Customized health action plans based on your needs and preferences • Personalized communications to assist you with making informed health decisions To start using our digital support tools, log in to the Aetna member website from www.RCBPhealth.com. First-time users will need to register.

	We offer several digital health and wellness related programs and resources: • Personal health record–organize and store your health history and information, plus get health alerts and notifications. • Health assessment – get a custom, step-by-step plan based on questions about your health and habits. • Health Decision Support – learn about your healthcare and treatment options. • Aetna Health Dashboard–view your health information, and find entry points to health and wellness programs and resources. • Additional member resources such as: Cancer Support, Joint Pain Support, and Maternity Support. Our Care Management Program includes the following programs and services. For more information about our Care Management Program or services, please call 800-638-8432 and select the correct prompt. We are available to assist you Monday-Friday from 6:00 a.m. to 5 p.m. Mountain Time (MST).
Back & Joint Care	Provides digital support for members dealing with musculoskeletal (MSK) issues, acute and chronic pain, and either taking opioids or trying to avoid opioids. The program helps you improve your quality of life by helping you manage and reduce your chronic MSK pain, without surgery or drugs. If RCBP identifies that there is an opportunity to help you improve your care, you will be invited to participate. Eligible participants will receive access to exercise therapy, motivational coaching, 1:1 support and education that is tailored to the participant's specific needs.
Behavioral Health Support	RCBP provides resources and support to help you address mental health or behavioral health conditions like anxiety, depression, substance use disorders, domestic violence and more. Our team will work with you, help you understand your benefits and guide you through the wellness programs we offer. We are here to support you, get you connected with a clinical social worker, psychologist or other behavior health professional to obtain the right treatment, the best services and resources to manage the daily obstacles that may be keeping you from achieving a healthier happy life.
Cancer Support	Provides dedicated proactive support to individuals along their cancer journey. We understand that a cancer diagnosis is life changing and can be overwhelming, and we are here to help you. Through our program, individuals will better understand their benefits, have the ability to locate the right provider for their specific need and get certain services approved. Individuals will also receive care management support for holistic care, treatment side effects, and medication management.
Compassionate Care	Offers you service and support when you or a family member have a serious illness or face imminent end-of-life decisions. The program provides you tools and information to encourage advanced planning for the kind of issues often associated with an advanced illness, such as living wills, advance directives, and tips on how to begin conversations about these issues with loved ones. This program is designed to provide quality of life improvement through health condition management and to reduce costs for you and your family at the end of life through timely member and caregiver education.
Social Work	Is designed to assist you in improving your quality of life by taking steps to help you locate the right resources. Social Workers can help connect you with community resources that can provide you services in times of need. Some examples include: • Local food pantries • Utility or rental assistance programs • Home-delivered meal services • Support groups • Counseling services

	• Federal and state programs Our social workers are licensed and degreed professionals with experience in a variety of settings, including government and non-profit organizations, hospitals, schools and clinics.
Lab Savings program	The Lab Savings program gives you the option of having covered outpatient laboratory testing paid at 100%, if your covered provider sends your lab work to Quest Diagnostics or LabCorp for processing. The Lab Savings program is an optional program. If you or your provider chooses not to participate in the Lab Savings Program, you will not be penalized. You will simply receive the regular Plan benefit for lab tests (see page 35). The Lab Savings program covers most outpatient laboratory testing covered by the Plan provided that the tests are ordered by a covered provider and processed by Quest Diagnostics or LabCorp. Outpatient lab work covered by the Lab Savings Program includes: blood tests (e.g., cholesterol, CBC, thyroid), urine testing (e.g., urinalysis), cytology and pathology (e.g., pap smear, biopsy) and cultures (e.g., throat culture). The Lab Savings program does not cover: lab tests ordered during a hospital stay, lab work needed on an emergency (STAT) basis and time sensitive lab tests such as fertility testing, bone marrow studies and spinal fluid tests. Lab Savings program also does not cover X-rays, imaging tests (e.g., CT scans, MRI scans, PET scans), mammography, dental work or lab testing processed by another lab testing company. For Lab Savings program services, please call Quest Diagnostics at 866-697-8378 or LabCorp at 888-522-2677 or search for Quest Diagnostics or LabCorp using your zip code in the Plan's online provider search tool website at www.RCBPhealth.com.
Pharmacy Advisor Program	If you have one or more of the following chronic conditions, you have the opportunity to discuss one-on-one with a CVS Health pharmacist any questions or concerns about the medication(s) you are taking. Please call toll-free 866-624-1481. • Diabetes • Congestive Heart Failure (CHF) • Coronary Artery Disease (CAD) • Hypertension (high blood pressure) • Dyslipidemia (high cholesterol) • Asthma • Chronic obstructive pulmonary disease (COPD) • Depression • Osteoporosis • Breast cancer
Aetna member website	**Aetna member website - Secure Member Portal** Access the Aetna member website by visiting www.RCBPhealth.com, then click on "Aetna member website" under "Member Resources". This provides you secure access to a broad range of your personal health information after you register. The **Aetna member website** provides tools to become an optimal healthcare consumer. Services such as the following are available: • **Interactive Personal Health Record** — The Plan will build your health record with information from your claims. You also can add other personal health information such as blood pressure, weight, vital statistics, immunization records, and more.

	• **Claims information** — You can view and organize your claims the way you want: sort by date range, healthcare provider etc. • **Explanation of Benefits (EOBs)** — You can access and print your EOBs. • **Decision support tools** — You can check the average cost of medical procedures or view hospital quality information before you receive care. • **Health information** — You can obtain health information and news that is relevant to you. • **Interactive health tools** — You can assess, understand, and manage conditions and health risks. Easy to use content helps members navigate common, but sometimes complex conditions. • **KidsHealth Library** — You can access an online resource that educates families and helps them make informed decisions about children's health. KidsHealth is an engaging way to encourage preventive behaviors and motivate kids and teens to become more involved in their health.
Aetna Health App	**After registration/log-in you can use the Aetna Health app to:** • Find doctors and facilities using location and see maps for directions • Locate urgent care - walk in clinics, urgent care, emergency room • View claims and claim details • View benefits and balances • Track out-of-pocket dollars • View ID card information • Store ID card offline • Get cost estimates before you receive care • View your Health History • Share your opinion (feedback) The app can be downloaded for free onto your mobile device. **How to Access:** • Android: Go to Play Store and search for Aetna Health. • iPhone: Go to App Store and search for Aetna Health. • Text”Aetna” to 90156 to receive a link to download the Aetna Health app (message and data rates may apply) **Supported Devices:** • Android • iPhone®
Wellness Incentive	Members (18 years of age and over, except well-child visits for children up to 15 months) who participate in the Wellness Incentive programs can earn up to $400 in rewards per calendar year. Complete the Health Risk Assessment (HRA) and $50 will be deposited in a Wellness Fund Account to use for certain eligible medical expenses. The questions help you uncover your health risks so you’re better able to manage them before they get out of control. Plus, once you take your HRA you receive a personalized health summary to help you better understand your health risks.

	Complete a biometric screening through Quest Diagnostics or LabCorp by November 30th of the calendar year and $100 will be deposited in a Wellness Fund Account to use for certain eligible medical expenses. You can obtain the biometric screening at a Quest Diagnostics Patient Service Center (PSC), through your physician by having your physician complete a Biometric Screening Physician Results Form and fax it back by the date above or through an at-home collection materials. To register for your screening or request an at-home collections materials call 855-623-9355 or to print a copy of the Biometric Screening Physician Results Form to take to your physician, visit https://my.questforhealth.com/mobile/welcome/home and enter the registration key: RCBP. Once your biometric screening is complete, your results will be available at https://my.questforhealth.com/mobile/welcome/home and will also be mailed to you to help you better understand your health risks. You can also obtain your biometric screening at a Labcorp Patient Service Center (PSC), through your physician by having your physician complete a Biometric Screening Physician Results Form and fax it back to Labcorp by the date above or through at home collection materials. For more information on how to register for your Labcorp screening or to request at-home collections materials visit https://RCBPhealth.com/wellness-rewards. Once your biometric screening is complete, your results will be available on Labcorp's portal. Members with the following conditions may be eligible to earn up to $100 for each incentive to be deposited in a Wellness Fund Account: **Controlling Blood Pressure for members with high blood pressure** • If you are identified or self-identify as having high blood pressure, we will provide you a form for your provider to complete. On the form, your provider must document two (2) controlled blood pressure readings below 140/90 on separate visits during the current calendar year for you to earn the incentive. • If you are unable to meet this goal, you will receive the incentive if one of the following is completed: - Dietary and nutritional counseling (obtain three counseling visits, which includes individual and group behavioral counseling). See Section 5(a). - Telephonic Health Coach Program (Tobacco Cessation, Weight Management, Exercise, Nutrition and Stress Management). **Controlling A1c Hemoglobin (HbA1c) levels for members with diabetes** • If you are identified or self-identify as having diabetes, ask your provider to submit your HbA1c laboratory results. Your HbA1c laboratory results must be less than 8% during the calendar year for you to earn the incentive. • If your HbA1c is greater than or equal to 8%, you will receive the incentive if one of the following is completed: - Dietary and nutritional counseling (obtain three counseling visits, which include individual and group behavioral counseling). See Section 5(a). - Diabetic Education or Training. See Section 5(a). - Telephonic Health Coach Program (Tobacco Cessation, Weight Management, Exercise, Nutrition and Stress Management). **Maternal Wellness - Complete and earn up to $200** • Enroll in Maternity Program by the 16th week of your pregnancy- $50 • Send provider documentation of prenatal visit in 1st trimester -$50 • Complete pre-delivery call between 27-32 weeks with Care Manager- $50

	• Complete a 4-week postpartum call with Care Manager -$50 **Well-child visits for children** • If you have a child, your child must complete six (6) or more well-child visits with a primary care provider within the first 15-months of their life. The well-child visits must occur on different dates of service and six visits must be completed on or before your child's 15-month birthday. The Plan may request your primary care provider's information or documentation to earn the wellness incentive. **Eliminating tobacco use for tobacco users** • If you are identified as a tobacco user you can participate in the Plan's Tobacco Cessation Program (see Section 5(a)). You must complete: - At least two quit attempts as part of our Tobacco Cessation Program. The quit attempt must include tobacco cessation counseling sessions of at least 30 minutes each. Note: To earn the incentive for the conditions outlined above, documentation needs to be mailed by December 31st of the calendar year to: Rural Carrier Benefit Plan C/O Wellness Incentive, P.O. Box 14079, Lexington, KY 40512-4079. **Complete any of the following Healthy Actions to earn additional incentives:** • Get your breast cancer screening and earn $100 • Get your cervical cancer screening (pap smear) and earn $100 • Get your colorectal cancer screening and earn $100 • Participate in our Telephonic Health Coaching Program and complete coaching sessions (see elsewhere in this Section) and earn $75 • Participate in our Telephonic Health Coaching Program for Weight Management (see elsewhere in this section). If you are taking a weight loss drug you can earn up to $75 per quarter. To earn this incentive you must: - Complete at least one (1) health coaching session per month; and - Provide your weight to your TrestleTree Health Coach monthly for tracking. - You can only earn one (1) of the Telephonic Health Coaching wellness incentives listed in this section. • Track your physical activity and earn up to $100 per quarter - Complete 5,000 steps or 30 minutes of physical activity per day for any 50 days - You can track this activity by connecting your activity device or by manually entering steps in the tracker activity. Visit the Plan's website (www.RCBPhealth.com), and then click on "Aetna Secure Member Website". Once you log on to the Aetna Secure Member Website, click on the "Health & Wellness" icon and then choose the "Explore Resources" under the "Discover a Healthier You" option to track your activity. Eligible Medical Expenses, as defined by Internal Revenue Code Section 213(d), include your deductible, coinsurance, and copayments (e.g., prescription drug copayments) incurred by you or your covered dependents.

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

	• You talk with your Health Coach over the phone through conveniently scheduled appointments and create a plan that is right for you to meet your health goals. Everything in the program is tailored to you. • You explore ways to make changes in your behavior that will last. • You receive written materials from your Health Coach that can help you decide where you want to go with your health and how to get there. • Appointments can range from 15 minutes to 30 minutes once a month or twice a month. How long and how often you meet with your Health Coach depends on your individual needs. To enroll in a program, contact a Health Coach at 855-553-5109. Coaches are available Monday through Thursday from 8:00 a.m. – 10:00 p.m. ET and Friday from 8:00 a.m. – 6:00 p.m. ET. You may also enroll online at www.enroll.trestletree.com (passcode: RCBP). Note: See Section 5(a), *Educational classes and programs* for more information.
Telephonic Health Coaching Program for Weight Management	The Telephonic Health Coaching Program for Weight Management combined with weight loss medications provides you with personalized support that help participants achieve lasting weight loss results. Participation in this program is mandatory and must be underway before starting your weight loss medication at our plan designated cost share. Each participant will be assigned a primary Health Coach who will provide personalized support and help you create an individualized plan and set realistic goals to help you succeed on your weight loss journey. Our focus is to guide you in making sustainable lifestyle behavior changes to your weight, diet, exercise, and stress. Coaching must continue while you are taking a weight loss medication. The frequency of the coaching visits will be determined by you and your health coach. Failure to continue coaching will result in termination of your weight loss medication coverage under RCBP. Members already taking weight loss medications prior to 1/1/2027 will be required to begin and continue health coaching in order to qualify for continued coverage of weight loss medications. To enroll in this program, contact TrestleTree at 855-553-5109. Coaches are available Monday through Thursday from 8:00 a.m. - 10:00 p.m. and Friday from 8:00 a.m. - 6:00 p. m. Eastern Time (ET). You may also enroll online at enroll.trestletree.com (passcode: RCBP). If you have any additional questions about the program, please contact us at 855-553-5109.
Health Risk Assessment	Make a difference in your health in just a few minutes by completing a simple Health Risk Assessment (HRA). It asks questions about your health history and habits. It can: • Help you learn more about your health risks, so you can take steps to lower them • Provide strategies to improve your health and well-being • Give you personalized health results to share with your doctor To schedule an appointment to complete your telephonic HRA, contact a Health Coach at 855-553-5109. Coaches are available Monday through Thursday from 8:00 a.m. – 10:00 p. m. ET and Friday from 8:00 a.m. – 6:00 p.m. ET. You can also schedule an appointment online at www.enroll.trestletree.com (passcode: RCBP).

Telehealth	RCBP offers access to Teladoc® telehealth consultations any time, 24/7/365 that is easy to use, private and secure. Teladoc is the nation's leading virtual care provider with over 3,600 board certified, state-licensed, primary care providers, pediatricians and specialists that have on average 20 years of experience and are available by web, phone and the Teladoc mobile app. With Teladoc, you can take care of most common issues such as: cold & flu symptoms, allergies, cough, sinus infection, respiratory infection, eye infection, skin problems and more. You can also see a therapist for ongoing counseling for concerns such as: depression, anxiety, stress, as well as for diet and nutrition assistance. **How to sign up:** 1. Download the iOS or Android App by searching "Teladoc" 2. Sign-up on the web at www.teladoc.com/Aetna 3. Sign-up by phone, call 855-835-2362 (855-Teladoc) Note: Teladoc does not replace your primary care provider. Teladoc does not guarantee that a prescription will be written. Teladoc operates subject to state regulations, see below. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services. • General Medical (via phone and video): Our general medical service is available in all 50 states, including D.C., and 4 U.S. territories (Puerto Rico, Guam, US Virgin Islands, Northern Mariana Islands). • Dermatology (via phone and video): Our dermatology service is available in all 50 states, including D.C. • Nutritional (via phone and video): Our nutritional service is available in all 50 states, including D.C. • Mental Health Care (via video only): Our mental health service is available in all 50 states, including D.C. If you have any questions or would like more information about the program, please call us at 800-638-8432.
Value Added Programs and Services	The Plan may offer a number of programs and services to members to maximize optimal health, reduce out of pocket costs, and assist with special conditions and needs as they become available during the year. Visit www.RCBPhealth.com for a current list of programs, program criteria, and contact information.

Non-PSHB Benefits Available to Plan Members

The benefits on this page are not part of the PSHB contract or premium, **and you cannot file a PSHB disputed claim about them.** Fees you pay for these services do not count toward PSHB deductibles or catastrophic protection (out-of-pocket maximums). These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 703-684-5552 or visit their website at www. nrlca.org.

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

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

When you use TruHearing, you also get:

- One year follow-up visits for fitting and adjustments;
- Risk free 60-day trial period;
- Three-year manufacturer's warranty for repairs and one-time loss and damage replacement;
- 80 free batteries per non-rechargeable hearing aid

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

EyeMed Vision Care Program - Save up to 35% with the EyeMed Vision Care discount program. Members are eligible for discounts on exams, glasses and contact lenses at thousands of providers nationwide. Members have access to over 27,000 providers at over 110,000 locations including optometrists, ophthalmologists, opticians and leading optical retailers such as: LensCrafters, participating Pearle Vision, Target Optical, and many independent providers.

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

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

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

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

NRLCA Group Insurance Department
1630 Duke Street, 2nd Floor
Alexandria, VA 22314-3466
703-684-5552

Section 6. General Exclusions - services, drugs and supplies we do not cover

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs or supplies for which no charge would be made if the covered individual had no health insurance coverage;
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Services, drugs, or supplies for "Never Events". Never Events are errors in patient care that can and should be prevented. The Plan will follow the policies of the Centers for Medicare and Medicaid Services (CMS) for Never Events. The Plan will not cover care that falls under the CMS policies. For additional information, visit www.cms.gov, and enter Never Events in the search box;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to clinical trials for extra care costs and research costs (see definitions);Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sexual dysfunction or impotence;
- Services, drugs, or supplies you receive from a provider or facility barred from the PSHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services, drugs, or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage, or adoption;
- Services, drugs, or supplies furnished by a facility not covered under the Plan, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to Plan limits;
- Any part of a provider's fee or charge that you would ordinarily pay but is waived by the provider. If a provider routinely waives (does not require you to pay) a deductible or coinsurance, we will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges which the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B, doctor's charges exceeding the amount specified by the U.S. Department of Health and Human Services when benefits are payable under Medicare (limiting charge) or State premium taxes however applied;
- Custodial care;
- Services, drugs, or supplies related to weight control or any treatment of obesity except as described in Section 5(a), *Medical services and supplies*, Section 5(f), *Prescription drug benefits*, and except for surgery for severe obesity as described in Section 5(b), *Surgical and anesthesia services*;
- Nonmedical services such as social services and recreational, educational, visual, and nutritional counseling except as described in Section 5(a) under *Nutritional Counseling*;
- Non-surgical treatment of temporomandibular joint (TMJ) dysfunction (except for biofeedback under Section 5(a), *Treatment Therapies*) including dental appliances, study models, splints and other devices;
- Services, drugs, or supplies for cosmetic purposes, except repair of accidental injury;
- Charges for completion of reports or forms;
- Charges for interest on unpaid balances;

- Charges for missed or canceled appointments;
- Charges to copy medical records needed by the Plan to process a claim. If the Plan requests medical records in error, the expenses will be covered;
- Telehealth/telemedicine fees such as transmission fees, care plan oversight, emails, patient monitoring or physician standby services billed by a healthcare provider;
- Membership or concierge service fees charged by a healthcare provider;
- Hypnotherapy, and milieu therapy;
- Biofeedback except as described in Section 5(a), *Treatment therapies*;
- Preventive medical care and services, except those provided under *Preventive care, adult* and *Preventive care*, children in Section 5(a);
- Private duty nursing care;
- Any services you receive related to a learning disability;
- Breast implants (except after mastectomy), injections of silicone or other substances, and all related charges, except as described in Section 5(a), *Orthopedic and prosthetic services*;
- Eyeglasses or contact lenses (except as covered under Vision services in Section 5(a); or
- Services and supplies not specifically listed as covered;
- Services or supplies we are prohibited from covering under the Federal Law;
- Chemical or surgical modification of an individual's sex traits through medical interventions (to include "gender transition" services);
- Any benefits or services required solely for your employment are not covered by this Plan.

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

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received).

See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures.

How to claim benefits

To obtain claim forms, claims filing advice or answers about our benefits, contact us at 800-638-8432, or at our website at www.RCBPhealth.com.

In most cases, providers and facilities file HIPAA compliant electronic claims for you. In cases where a paper claim must be used, the provider must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at 800-638-8432.

When you must file a claim – such as for services you received overseas or when another group health plan is primary – submit it on the CMS-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Patient's name, date of birth, address, phone number and relationship to enrollee
- Patient's Plan identification number
- Name, address and tax identification number of the person or company providing the service or supply
- Dates that services or supplies were furnished
- Diagnosis
- Valid medical or ADA dental code if it exists or a description of each service or supply; and
- Charge for each service or supply

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

In addition:

- Generally, you need to complete only one claim form each calendar year. You should also complete a new claim form if the claim is for an accidental injury, your mailing address changes, or if your other insurance/Medicare coverage changes.
- You must send a copy of the explanation of benefits (EOB) form you received from any primary payor (such as the Medicare Summary Notice (MSN)) with your claim. See Section 9 for Medicare claims.
- Claims for rental or purchase of durable medical equipment must include the price of the equipment, a prescription and a written statement from the provider specifying the medical necessity, including the diagnosis, and the estimated length of time needed.
- Claims for dental care must include a copy of the itemized bill from the dentist (including the information above) and the dentist's Federal Tax ID number. The Plan does not have a separate dental claim form.

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

Post-service claims procedures

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

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

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

Records

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

Deadline for filing your claim

Send us all the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service. If you could not file on time because of Government administrative operations or legal incapacity, you must submit your claim as soon as reasonably possible. Once we pay benefits, there is a three year limitation on the re-issuance of uncashed checks.

Overseas claims

Follow the same procedures when submitting claims for overseas (foreign) services as you would when submitting claims for stateside services. Claims for overseas services should include an English translation. We will use the U.S. dollar exchange rate applicable on the date service was incurred if you do not supply us with a currency exchange rate along with a paid receipt.

Overseas providers (those outside the 50 United States) will be paid at the in-Network level of benefits for covered services. Overseas hospitals and physicians are under no obligation to file claims for you. **You may be required to pay for the services at the time you receive them and then submit a claim to us for reimbursement.** If you have questions about the processing of overseas claims, contact us at 800-638-8432

When we need more information

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

Authorized Representative

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

Notice Requirements

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

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

Section 8. The disputed claims process

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

If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D Prescription Drug Plan (PDP) Employer Group Waiver Plan (EGWP) and you disagree with our **pre-service or post-service** decision about your prescription drug benefits, please, follow the appeals process outlined in Section 8(a). Medicare PDP EGWP Disputed Claims Process.

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department at 800-638-8432 or by writing Rural Carrier Benefit Plan, P O Box 14079, Lexington, KY 40512-4079.

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

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

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

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: 1. Write to us within 6 months from the date of our decision; and 2. Send your request to us at: Rural Carrier Benefit Plan, P O Box 14079, Lexington, KY 40512-4079; and 3. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and 4. Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. 5. Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: 1. Pay the claim or 2. Write to you and maintain our denial or. 3. Ask you or your provider for more information.

	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Postal Service Insurance Operations (PSIO), 1900 E Street, NW, Room 5478, Washington, DC 20415. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 800-638-8432. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's PSIO at (202) 936-0002 between 8 a.m. and 5 p.m. Eastern Time.

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

Reminder: If you are a Postal Service annuitant, or their covered Medicare-eligible family member, enrolled in our Medicare Part D PDP EGWP you may appeal an adverse pre-service or post-service determination. See Section 8(a).

Section 8(a). The Medicare Part D PDP EGWP Plan Sponsored Disputed Claims Process

When a Medicare Part D PDP EGWP claim is denied in whole or in part, you may appeal the denial.

As a Medicare Prescription Drug Plan Organization contracted with the Centers for Medicare & Medicaid Services (CMS) to offer Prescription Drug Plans (PDP), SilverScript handles complaints and appeals in accordance with CMS requirements.

SilverScript Medicare standard appeals and Medicare expedited appeals process

SilverScript has a Medicare s*tandard* appeals process and a Medicare e*xpedited* appeals process. SilverScript must notify a beneficiary in writing of any decision (partial or complete) to deny a claim or service. The notice must state the reasons for the denial and the right to a file an appeal. If it is then decided to proceed with the Medicare standard appeals process, the following steps will occur:

- The enrollee/requestor must ask for an appeal by making a written request to SilverScript and must file his/her request within 60 days of the date on the written adverse coverage determination notice.
- Standard appeal decisions (favorable or unfavorable) for covered drug benefits for request for payment must be provided to the enrollee in writing no later than 7 calendar days of receipt of the appeal request.
- Failure to meet the time frames noted constitutes an adverse determination and SilverScript must forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication time frame for the IRE to issue the appeal (redetermination) decision. This applies to both standard and expedited appeal requests.
- Enrollee can request an expedited appeal review for any items outlined in the coverage determinations section for which an enrollee received an adverse coverage determination. If we denied an expedited appeal, an enrollee has the right to resubmit his/her request for an expedited appeal with the prescribing physician's support.

If SilverScript decides to uphold the original adverse decision, either in whole or in part, you are sent a letter which explains your right to file an appeal. In that letter, you are provided with instructions on how to file the appeal by submitting their request to MAXIMUS Federal Services, Inc. for a new and impartial review. MAXIMUS is CMS's independent contractor for appeal reviews involving SilverScript Prescription Drug care plans.

For additional questions about the appeals process, contact SilverScript Customer Care at 833-825-6754.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

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

When we are the primary payor, we will pay the benefits described in this brochure. When we are the secondary payor, we will determine our allowance. After the primary plan processes the benefit, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

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

Please see Section 4, *Your Costs for Covered Services,* for more information about how we pay claims.

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

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

We do not cover services that:

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

- **Medicaid**

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

Suspended PSHB coverage to enroll in Medicaid or a similar state-sponsored program of medical assistance: If you are an annuitant, you can suspend your PSHB coverage to enroll in one of these state programs, eliminating your PSHB premium. For information on suspending your PSHB enrollment, contact your retirement or employing office. If you later want to re-enroll in the PSHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

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

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

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

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

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

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

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

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

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

- Payments directly from the responsible party, and
- Funds or accounts established through settlement or judgment to compensate injured parties

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

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

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

Failure to cooperate with these obligations may result in the temporary suspension of your benefits and/or offsetting of future benefits.
For more information about this process, please call our Third Party Recovery Services unit at 202-683-9140 or 855-661-7973 (toll free). You also can email them at info@estprs.com.

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

Some PSHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your PSHB Plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on www.BENEFEDS.gov or by phone at 877-888-3337, (TTY 877-889-5680), you will be asked to provide information on your PSHB Plan so that your plans can coordinate benefits. Providing your PSHB information may reduce your out-of-pocket cost.

Clinical trials

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

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

- Routine care costs – costs for routine services such as doctor visits, lab tests, X-rays and scans, and hospitalizations related to treating the patient’s condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient’s routine care. This Plan does not cover these costs.

- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trial. This Plan does not cover these costs.

When you have Medicare

For more detailed information on "What is Medicare?" and "When do I Enroll in Medicare?" please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www. medicare.gov.

Important Note: Subject to limited exceptions, Postal Service annuitants entitled to Medicare Part A and their eligible family members who are entitled to Medicare Part A are required to enroll in Medicare Part B to maintain eligibility for the PSHB Program in retirement.

If you are required to enroll in Medicare Part B and fail to do so at your first opportunity, you may be disenrolled (annuitants) and/or your family members removed from coverage.

For more information on these requirements, please contact 800-638-8432.

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

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

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

  When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care except you do not need to get a hospital stay approved when Medicare pays first. We do not require preauthorization and concurrent review of mental health and substance misuse disorder treatment when Medicare Part B pays first. However, when Medicare stops paying benefits for any reason, you must follow our precertification, preauthorization and concurrent review procedures.

  Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

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

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

  We waive some costs if the Original Medicare Plan is your primary payor.

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

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

Benefit Description: Catastrophic Protection Out-of-Pocket Maximum
High Option You pay without Medicare In-Network: $5,000/$10,000
High Option You pay without Medicare Out-of-network: $7,000/$14,000
High Option You pay with Medicare In-network: $5,000/$10,000
High Option You pay with Medicare Out-of-network: $7,000/$14,000

Benefit Description: Part B Premium Reimbursement Offered
High Option You pay without Medicare In-Network: N/A
High Option You pay without Medicare Out-of-network: N/A
High Option You pay with Medicare In-network: N/A
High Option You pay with Medicare Out-of-network: N/A

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

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

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

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

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

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

Call us at 800-638-8432 for more information about how we coordinate benefits with Medicare.

- **Tell us about your Medicare coverage**

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

- **Private contract with your physician**

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

- **Medicare Advantage (Part C)**

  If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private healthcare choices (like HMOs and regional PPOs) in some areas of the country.

  To learn more about Medicare Advantage plans, contact Medicare at 800-MEDICARE (800-633-4227), (TTY 877-486-2048) or at www.medicare.gov.

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

  This Plan and our Medicare Advantage plan: You may enroll in Rural Carrier Benefit Plan and our national Aetna Medicare Advantage for Rural Carrier Benefit Plan PSHB if you are an annuitant or former spouse with primary Medicare Parts A and B. Enrollment in the Aetna Medicare Advantage for Rural Carrier Benefit Plan is voluntary. Our Medicare Advantage plan will enhance your PSHB coverage by lowering/eliminating cost-sharing for services and/or adding benefits at no additional cost. Aetna Medicare Advantage for Rural Carrier Benefit Plan is subject to Medicare rules. You can enroll in our Medicare Advantage plan with no additional premium. If you are already enrolled and would like to understand your additional benefits in more detail, please call us at 866-241-0262, Monday - Friday 8 a.m. to 8:00 p.m. (Eastern standard time), go to www.AetnaRetireeHealth.com/RCBPPostal, or you may also refer to your Medicare plan's Evidence of Coverage. Once you enroll in our Aetna Medicare Advantage for Rural Carrier Benefit Plan, we will send you additional information.

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

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

  Part B Premium Reduction
  We will reduce the Part B premium that you pay to the Social Security Administration by $100 per month. If you pay your Part B premium on a monthly basis, you will see this dollar amount credited in your Social Security check. If you pay your Part B premium quarterly, you will see an amount equaling three months of reductions credited on your quarterly Part B premium statement. It may take a few months to see these reductions credited to either your Social Security check or premium statement, but you will be reimbursed for any credits you did not receive during this waiting period.

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

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

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

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

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

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you (as an active employee eligible for Medicare Part D or their covered Medicare Part D-eligible family member) enroll in any open market Medicare Part D plan and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by that Medicare Part D plan and consider them for payment under the PSHB Plan.

Note: If you are a Postal Service annuitant or their covered Medicare-eligible family member enrolled in our Medicare Part D-eligible family member enrolled in our Medicare Part D PDP EGWP, this does not apply to you because you may not be enrolled in more than one Medicare Part D plan at the same time. If you opt out of or disenroll from our PDP EGWP you do not have our PSHB Program prescription drug coverage and we are not a secondary payor for prescription drug benefits.

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

If you are enrolled in Medicare Part A and/or Part B, and are not enrolled in our Aetna Medicare Advantage Prescription Drug Plan (MAPD) for Rural Carrier Benefit Plan, you will be automatically group enrolled into our Medicare PDP EWGP. Our PDP EGWP is a prescription drug benefit for Postal Service annuitants and their covered Medicare-eligible family members. This allows you to received benefits that will never be less than the standard prescription drug coverage that is available to members with non-PDP EGWP prescription drug coverage. But more often you will receive benefits that are better than members with standard non-PDP EGWP prescription drug coverage. **Note: You have the choice to opt out or disenroll from our PDP EGWP at any time and may obtain prescription drug coverage outside of the PSHB Program.**

When you are enrolled in our Medicare PDP EGWP for your prescription drug benefits you continue to have our medical coverage.

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

For people with limited income and resources, Extra Help is a Medicare program to help with Medicare prescription drug plan costs. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 TTY 800-325-0778. You may also contact SilverScript at 833-825-6754.

The PDP EGWP opt out process:

If you were automatically group enrolled into our PDP EGWP and want to opt out, you may do so by following the instructions mailed to you or by calling SilverScript at 833-825-6754.

The PDP EGWP disenrollment process:

When you are enrolled in our PDP EGWP, you may choose to disenroll at any time. Contact us at 833-825-6754 for instructions.

WARNING: If you opt out or disenroll from our PDP EGWP, you will not have any PSHB Program prescription drug coverage.

Note: If you choose to opt out or disenroll from our PDP EGWP, your premium will not be reduced, and you may have to wait to re-enroll when and if you are eligible. If you do not maintain creditable coverage, re-enrollment in our PDP EGWP may be subject to a late enrollment penalty. Contact us for assistance at 833-825-6754.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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

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

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

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

If you:

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

Then, for your inpatient hospital care:

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

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

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

If your physician:
Participates with Medicare or accepts Medicare assignment for the claim and is in-network,
Then you are responsible for:
your deductibles, coinsurance, and copayments.

If your physician:
Participates with Medicare and is out-of-network,
Then you are responsible for:
your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount.

If your physician:
Does not participate with Medicare,
Then you are responsible for:
your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount.

If your physician:
Does not participate with Medicare and is out-of-network,
Then you are responsible for:
your out-of-network deductibles, coinsurance, and any balance up to 115% of the Medicare approved amount

If your physician:
Opts-out of Medicare via private contract
Then you are responsible for:
your deductibles, coinsurance, copayments, and any balance your physician charges

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

Physicians Who Opt-Out of Medicare

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

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

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

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

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

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

If your physician accepts Medicare assignment, then you pay nothing for covered charges.

If your physician does not accept Medicare assignment, then you pay the difference between the “limiting charge” or the physician’s charge (whichever is less) and our payment combined with Medicare’s payment.

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

Section 10. Definitions of terms we use in this brochure

Acupuncture

The practice of insertion of needles into specific exterior body locations to relieve pain, to induce surgical anesthesia, or for therapeutic purposes.

Admission

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

Assignment

An authorization by you (the enrollee or covered family member) that is approved by us (the Carrier), for us to issue payment of benefits directly to the provider.

- We reserve the right to pay you directly for all covered services. Benefits payable under the contract are not assignable by you to any person without express written approval from us, and in the absence of such approval, any assignment shall be void.
- Your specific written consent for a designated authorized representative to act on your behalf to request reconsideration of a claim decision (or, for an urgent care claim, for a representative to act on your behalf without designation) does not constitute an Assignment.
- OPM’s contract with us, based on federal statute and regulation, gives you a right to seek judicial review of OPM's final action on the denial of a health benefits claim but it does not provide you with authority to assign your right to file such a lawsuit to any other person or entity. Any agreement you enter into with another person or entity (such as a provider, or other individual or entity) authorizing that person or entity to bring a lawsuit against OPM, whether or not acting on your behalf, does not constitute an Assignment, is not a valid authorization under this contract, and is void.

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Chiropractic

A system of therapy that attributes disease to abnormal function of the nervous system and attempts to restore normal function by manipulation of the spinal column and other body structures.

Clinical trials cost categories

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

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

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See Section 4.

Copayment

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

Cost-sharing

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

Covered services

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

Custodial care

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

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

We determine what treatments or services is custodial care.

Deductible

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

Experimental or investigational services

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

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

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

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

Genetic screening

The diagnosis, prognosis, management, and prevention of genetic disease for those patients who have no current evidence or manifestation of a genetic disease and those who we have not determined to have an inheritable risk of genetic disease.

Genetic testing

The diagnosis and management of genetic disease for those patients with current signs and symptoms and for those who we have determined to have an inheritable risk of genetic disease.

Healthcare professional

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

Home healthcare agency

A public agency or private organization under Medicare that is licensed as a home healthcare agency by the State and is certified as such.

Home healthcare plan

A plan of continued care and treatment when you are under the care of a physician, and when certified by the physician that, without the home healthcare, confinement in a hospital or skilled nursing facility would be required.

Infertility

Infertility services for Artificial Insemination (AI) will be considered medically necessary for any member unable to conceive, regardless of relationship status or sexual orientation. For ovulation induction (OI) and Advanced Reproductive Technology (ART), the Plan will continue to require prior authorization and will utilize Aetna's medical necessity criteria to determine coverage. The Plan will cover AI as a core medical benefit, members will no longer need to meet a definition or obtain prior authorization.

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

Long term rehabilitation therapy

Physical, speech, and occupational therapy, which can be expected to last longer than a two month period in order to achieve a significant improvement in your condition.

Medical foods

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

Medical necessity

Services, supplies, drugs or equipment provided by a hospital or covered provider of the healthcare services that we determine are appropriate to diagnose or treat your condition, illness, or injury and that:

- are consistent with standards of good medical practice in the United States;
- are clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and
- are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
- are not a part of or associated with the scholastic or vocational training of the patient; and
- in the case of inpatient care, cannot be provided safely in an outpatient setting.

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

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

Medicare Part A

Part A helps cover inpatient hospital stays, skilled nursing facility care, hospice care, and some home health care.

Medicare Part B

Part B covers medically necessary services like doctors' services and tests, outpatient care, home health services, durable medical equipment, and other medical services.

Medicare Part C

Part C is a Medicare Advantage plan that combines the coverage of Medicare Part A and Part B. Part C typically also covers additional benefits like, dental, vision, and hearing services. Some Part C plans also include Medicare Part D coverage.

Medicare Part D

Medicare Part D plans provide coverage for prescription drugs. Private insurers contract with CMS on an annual basis for the right to offer Part D plans. Part D can be offered as a standalone Prescription Drug Plan (PDP) or as part of a Medicare Advantage Prescription Drug Plan (MAPD).

Medicare Part D PDP EGWP

A Medicare Part D Employer Group Waiver Plan (EGWP) is a type of Medicare prescription drug plan that can be offered to employees and retirees of certain companies, unions, or government agencies, which allows for flexibility and enhanced coverage of traditional Medicare pharmacy benefits. Examples of Medicare Part D EGWPs are Medicare Advantage Prescription Drug (MAPD) plan EGWPs that include both health and drug benefits, as well as Prescription Drug Plan (PDP) EGWPs, which only cover the prescription drug benefit.

Mental health conditions/ substance use disorder

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

Observation Care

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

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

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

Plan allowance

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

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

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

If you receive services from other participating providers, the Plan’s allowance will be the amount that the provider has negotiated and agreed to accept for the services and or supplies. Benefits will be paid at Out-of-network benefit levels, subject to the applicable deductibles, coinsurance and copayments.

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

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

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

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

Prosthetic device An artificial substitute for a missing body part, such as an arm or a leg, used for functional reasons, because a part of the body is permanently damaged, is absent or is malfunctioning. A prosthetic device is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body.

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

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

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

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

Surprise bill An unexpected bill you receive for:

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

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

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

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

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

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

Us/We	Us and We refer to the Rural Carrier Benefit Plan.
Walk-in clinic	A medical facility that accepts patients on a walk-in basis; no appointment is required. Provides non-emergency, basic healthcare services on a walk-in basis. Examples include MinuteClinic® at CVS Pharmacy locations and Healthcare Clinics in Walgreens pharmacy locations. Urgent care clinics are not considered walk-in clinics.
You	You refers to the enrollee and each covered family member.

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

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Summary of Benefits for the High Option of the Rural Carrier Benefit Plan - 2027

Do not rely on this chart alone. This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please read this PSHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www. RCBPhealth.com.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

Below, an asterisk (*) means the item is subject to the $350 in-network/$800 out-of-network calendar year deductible. And a double asterisk (**) means the item is subject to the $200 prescription drug deductible. After we pay, you generally pay any difference between our allowance and the billed amount if you use an out-of-network physician or other healthcare professional.

High Option Benefits	You pay	Page
Protection against catastrophic costs (out-of-pocket maximum):	**In-network:** Nothing after $5,000 for Self Only enrollment or $10,000 for Self Plus One or Self and Family enrollment per calendar year including CVS Health in-network retail and/or mail service pharmacy. **Out-of-network:** Nothing after $7,000 for Self Only enrollment or $14,000 for Self Plus One or Self and Family per calendar year including CVS Health in-network retail and/or mail service pharmacy. Note: Benefit maximums apply and some costs do not count toward this protection.	24
Medical services provided by physicians: Diagnostic and treatment services provided in the office	**In-network primary care provider:** $20/ office visit for primary care services; $35/ office visit for specialist care services **Out-of-network:** 30% of our allowance* and any difference between our allowance and the billed amount	29
Medical services provided by physicians: Telehealth	**In-network:** $20/office visit for primary care services; $35/office visit for specialist care services **Out-of-network:** 30% of the Plan allowance* and any difference between our allowance and the billed amount	29
Medical services provided by physicians: Surgery	**In-network:** 15% of our allowance **Out-of-network:** 30% of our allowance* and any difference between our allowance and the billed amount	51
Services provided by a hospital: Inpatient	**In-network:** $200 copayment per admission (waived for maternity stay) **Out-of-network:** $400 copayment per admission; 30% of covered charges	64
Services provided by a hospital: Outpatient	**In-network:** 15% of our allowance* (cost-share is waived for maternity services)	65

	Out-of-network: 30% of our allowance* and any difference between our allowance and the billed amount	
Emergency benefits: Accidental injury	**In-network:** Nothing for initial emergency room visit, initial urgent care visit, or first physician office visit **Out-of-network:** The difference between the Plan allowance and the billed amount for initial emergency room visit, initial urgent care visit, or first physician office visit	69-70
Emergency room benefits: Medical emergency	**In-network:** $20/office visit for primary care services; $35/office visit for specialist care; $200/ outside primary care or specialist provider's office - $200 copayment **Out-of-network:** 15% of the Plan allowance and any difference between our allowance and the billed amount when services provided in a primary care provider or specialist provider's office; $200 copayment and any difference between our allowance and the billed amount when services provided outside the primary care provider's or specialist provider's office	69-70
Mental health and substance use treatment: Applied Behavioral Analysis (ABA)	**In-network:** 15% of the Plan allowance **Out-of-network:** 30% of the Plan allowance* and any difference between our allowance and the billed amount	71
Mental Health and substance use treatment: Inpatient	**In-network:** $200 copayment per admission **Out-of-network:** 30% of the Plan allowance* and any difference between our allowance and the billed amount	72
Mental health and substance use treatment: Outpatient	**In-network:** 15% of the Plan allowance* **Out-of-network:** 30% of the Plan allowance* and any difference between our allowance and the billed amount	73
Prescription drugs: Network and Non-Network Retail pharmacy	30% of cost**	78
Prescription drugs: Mail Order pharmacy	Up to a 90 day supply: Tier I - $10/generic; Tier II - $50/preferred brand name; Tier III - $80/non-preferred brand name; Tier IV-- Specialty Generic drugs $70 for a 30 day supply/$100 for a 90 day supply; Tier V - Specialty Preferred drugs $90 for a 30 day supply/$125 for a 90 day supply; Tier VI - Specialty Non-Preferred drugs $120 for a 30 day supply/$250 for a 90 day supply	78
Dental care:	Any difference between our scheduled allowance and the billed amount	88
Wellness and Other Special features:		90

	Flexible benefits Option; Institutes of Excellence (IOE); Gene-Based, Cellular and Other Innovative Therapies (GCIT™) Designated Network; 24-Hour Nurse Line; Healthy Maternity Program; Complex and Chronic Disease Management Program; Care Management Program; Back and Joint Care; Behavioral Health Support; Cancer Support; Compassionate Care; Social Work; Lab Savings Program; Pharmacy Advisor Program; Aetna member website; Aetna Health app; Wellness Incentive; Comprehensive Pain Management Program; Telephonic Health Coach Program; Telephonic Health Coaching Program for Weight Management; Health Risk Assessment; Telehealth; Value Added Programs and Services	

Notes

2027 Rate Information for Rural Carrier Benefit Plan

To compare your PSHB health plan options please go to https://health-benefits.opm.gov/PSHB/.

To review premium rates for all PSHB health plan options please go to www. opm.gov/healthcare-insurance/pshb/premiums/.

Type of Enrollment	Enrollment Code	Premium Rate			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
High Option Self Only	79A	$318.23	$179.37	$689.50	$388.63
High Option Self Plus One	79C	$689.34	$346.96	$1,493.57	$751.75
High Option Self and Family	79B	$748.55	$339.96	$1,621.86	$736.58