

Rural Carrier Benefit Plan: High Option

Summary of Benefits and Coverage

Coverage Period: 01/01/2016 – 12/31/2016

Coverage for: Self Only, Self Plus One or Self and Family | Plan Type: Network Providers



This is only a summary. Please read the FEHB Plan brochure (RI 72-005) that contains the complete terms of this plan. **All benefits are subject to the definitions, limitations, and exclusions set forth in the FEHB Plan brochure.** Benefits may vary if you have other coverage, such as Medicare. You can get the FEHB Plan brochure at www.rcbphealth.com or by calling 1-800-638-8432.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: \$350 Self Only; \$700 Self Plus One and Self & Family; Out-of-network: \$400 Self Only; \$800 Self Plus One and Self & Family; Not applicable to in-network preventive care, surgery, office visits, inpatient hospital or prescription drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for certain covered services you use. Copayments and coinsurance amounts do not count toward your deductible , which generally starts over January 1st. When a covered service or supply is subject to a deductible , only the Plan allowance for the service or supply counts toward the deductible . See the chart starting on page 2 for how much you pay for covered services after you meet the deductible and for which services are subject to the deductible .
Are there other deductibles for specific services?	\$200/person for retail prescriptions. \$50/person for dental coverage.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	In-network only: \$4,000 Self Only; \$4,500 Self Plus One and Self & Family (\$4,000 per covered individual) Out-of-network: \$5,000 Self Only; \$5,500 Self Plus One and Self & Family (\$5,000 per covered individual)	The out-of-pocket limit , or catastrophic maximum, is the most you could pay during the year for your share of the cost of covered services. This limit helps you plan for health care expenses. The “per covered individual” amount is the most that any one member would have to pay, regardless of whether the individual is enrolled in Self Plus One, or Self and Family.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, dental, penalties, and non-covered services.	Even though you pay these expenses, they don’t count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
Does this plan use a network of providers?	Yes. See www.rcbphealth.com or call 1-800-638-8432 for in-network provider list.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a specialist?	No	
Are there services this plan doesn’t cover?	Yes	Some of the services this plan doesn’t cover are listed on page 4. See this plan’s FEHB brochure for additional information about excluded services .

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- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider (plus you may be balance billed)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay	25% coinsurance	Deductible applies to Out-of-network.
	Specialist visit	\$20 copay	25% coinsurance	Deductible applies to Out-of-network.
	Other practitioner office visit	\$20 copay/visit for chiropractor; 15% coinsurance for acupuncture and massage therapy	25% coinsurance for chiropractor, acupuncture and massage therapy	Max 30 visits/ person/ year for acupuncture and massage therapy. Deductible applies to Out-of-network chiropractor.
	Preventive care/ screening/immunization	No charge	25% coinsurance for screenings and preventive care	Out-of-network deductible applies for adult screenings and preventive care. Nothing up to plan allowance for immunizations for out-of-network.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance; nothing if Lab Card provider used	25% coinsurance	Deductible applies to In and Out-of-network except for Lab Card providers.
	Imaging (CT/PET scans, MRIs)	15% coinsurance, no charge if provided at a stand-alone imaging center	25% coinsurance	Deductible applies to In and Out-of-network except for in- network stand-alone imaging centers. Pre-authorization required.

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If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.Caremark.com .	Generic drugs	\$200/person retail deductible then 30%; Mail: \$10 copay	\$200/ person retail deductible then 30%; mail not covered	Max 30-day (retail)/90-day (mail). 90-day for maintenance drugs only covered at mail or network pharmacy after 3 retail fills.
	Preferred brand drugs	\$200/ person retail deductible then 30%; Mail: \$30 copay	\$200/ person retail deductible then 30%; mail not covered	Max 30-day (retail)/90-day (mail). Mail: \$20 copay for network pharmacy and Medicare Part B is primary. 90-day maintenance drugs only covered at mail or network pharmacy after 3 retail fills.
	Non-preferred brand drugs	\$200/ person retail deductible then 30%; Mail: \$47 copay	\$200/ person retail deductible then 30%; mail not covered	Max 30-day (retail)/90-day (mail). Mail: \$37 copay for network pharmacy and Medicare Part B is primary. 90-day maintenance drugs only covered at mail or network pharmacy after 3 retail fills.
	Specialty drugs	\$200/ person retail deductible then 30%; Mail: \$80 copay	\$200/ person retail deductible then 30%; mail not covered	Max 30-day (retail)/90-day (mail). Mail: 90-day maintenance drugs only covered at mail order or network pharmacy after 3 retail fills. Preauthorization required.
If you have outpatient surgery	Facility fee (e.g. ambulatory surgery center)	15% coinsurance	30% coinsurance	Deductible applies to In and Out-of-network.
	Physician/surgeon fees	10% coinsurance	25% coinsurance	Deductible applies to Out-of-network.
If you need immediate medical attention	Emergency room services	15% coinsurance	15% coinsurance	Nothing for accident.
	Emergency medical transportation	15% coinsurance	15% coinsurance	
	Urgent care	\$35 copay/visit	15% coinsurance	Nothing for accident. Deductible applies to Out-of-network.
If you have a hospital stay	Facility fee (e.g. hospital room)	\$100 copay/admission	\$300 copay/admission and 25% coinsurance	Precertification is required.
	Physician/surgeon fee	15% coinsurance physician/10% surgeon	25% coinsurance	Deductible applies except In-network physician.

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If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	15% coinsurance for other outpatient services	30% coinsurance	Deductible applies except for In-network office visits. Partial hospitalization requires preauthorization.
	Mental/Behavioral health inpatient services	\$100 copay/ admission	\$300 copay/ admission and 25% coinsurance	Precertification is required
	Substance use disorder outpatient services	15% coinsurance for other outpatient services	30% coinsurance	Deductible applies except for In-network office visits. Partial hospitalization requires preauthorization.
	Substance use disorder inpatient services	\$100 copay/ admission	\$300 copay/ admission and 25% coinsurance	Precertification is required
If you are pregnant	Prenatal and postnatal care	No charge	25% coinsurance	Deductible applies to Out-of-network
	Delivery and all inpatient services	No charge	25% coinsurance	Deductible applies to Out-of-network
If you need help recovering or have other special health needs	Home health care	15% coinsurance	25% coinsurance	Limit 90 visits/ year if preauthorized otherwise limit 40 visits. Deductible does not apply.
	Rehabilitation services	15% coinsurance	25% coinsurance	Limited to 90 visits per year combined
	Habilitation services	15% coinsurance	25% coinsurance	Limited to 90 visits per year combined
	Skilled nursing care	Nothing for first 60 days if preauthorized	Nothing for first 60 days if preauthorized	If not preauthorized, 30 day limit and 20% coinsurance. Deductible does not apply.
	Durable medical equipment	15% coinsurance	25% coinsurance	Deductible applies
	Hospice service	15% coinsurance	30% coinsurance	Deductible does not apply
If your child needs dental or eye care	Eye exam	All charges over \$45	All charges over \$45	Benefit limited to \$45 for routine eye exam
	Glasses	15% coinsurance	25% coinsurance	Cover one pair of glasses with standard frames and be related to an accidental injury or intraocular surgery. Deductible applies.
	Dental check-up	No charge for two preventive care exams/ person/ year	No charge for two preventive care exams/ person/ year	Member pays all charges exceeding Plan's scheduled allowance for the service.

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check this plan's FEHB brochure for other excluded services.)

- Cosmetic surgery
- Custodial care
- Long-term care
- Private-duty nursing
- Routine foot care

Other Covered Services (This isn't a complete list. Check this plan's FEHB brochure for other covered services and your costs for these services.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- Infertility treatment
- Massage therapy
- Non-emergency care when traveling outside the U.S.
- Weight loss programs

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending on the circumstances, you may be eligible for a 31-day free extension of coverage, to convert to an individual policy, and to receive temporary continuation of coverage (TCC). Your TCC rights will be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. An individual policy may also provide different benefits than you had while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, see the FEHB Plan brochure, contact your HR office/retirement system, contact your plan at 1-800-638-8432 or visit www.opm.gov/insure/health.

Your Appeal Rights:

If you are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal. For information about your appeal rights please see Section 3, "How you get care," and Section 8 "The disputed claims process," in your plan's FEHB brochure. If you need assistance, you can contact: 1-800-638-8432.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **Coverage under this plan qualifies as minimum essential coverage.**

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Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.**

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-800-638-8432.]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-638-8432.]

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-638-8432.]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-638-8432.]

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$7,370
- Patient pays \$170

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$20
Copays	\$0
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$170

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,230
- Patient pays \$1,665

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$350
Copays	\$540
Coinsurance	\$200
Limits or exclusions	\$80
Total	\$1,170

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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