

Presbyterian Health Plan

<http://www.phs.org>

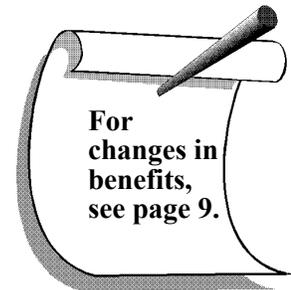


2009

A Health Maintenance Organization (High and Standard options)

Serving: All counties of New Mexico

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.



Enrollment code for this Plan:

High Option

- P21 Self Only
- P22 Self and Family

Standard Option

- P24 Self Option
- P25 Self and Family

This Plan has Commendable accreditation from NCQA.

See the 2009 Guide for more information on accreditation.



Authorized for distribution by the:



**United States
Office of Personnel Management**

Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-563

**Important Notice from Presbyterian Health Plan About
Our Prescription Drug Coverage and Medicare**

OPM has determined that Presbyterian Health Plan prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and Presbyterian Health Plan will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop our coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% 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'll 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 (November 15th through December 31st) 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 1-800-772-1213 (TTY 1-800-325-0778).

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

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

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Introduction

This brochure describes the benefits of Presbyterian Health Plan under our contract (CS 2627) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Presbyterian Health Plan's administrative offices is:

Presbyterian Health Plan

2501 Buena Vista SE

Albuquerque, NM 87106

Or

P.O. Box 27489

Albuquerque, NM 87125-7489

This brochure is the official statement of benefits. No oral 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 and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your health care providers, authorized health benefit plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care 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) statement that you receive from us.
- 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 505/923-5678 or toll-free 1-800-356-2219 or TTY for the hearing impaired at 505/923-5699 or toll-free at 1-877-298-7407 and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

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

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That’s about 3,230 preventable deaths in the FEHB Program a year. 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. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. 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 ask questions and understand answers.

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- 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 medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. 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 health care providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- 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 health care professionals working to improve patient safety.

- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurances described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. Our Fee Schedule is based on the Resource Base Relative Value Scale (RBRVS). The RBRVS method was designed by physicians to fairly compensate themselves based on:

1. a nationally uniform relative value for service;
2. geographic adjustment factor; and
3. a nationally uniform conversion factor for service.

This method has been adopted by our Federal Centers for Medicare and Medicaid Services for Medicare reimbursement.

The RBRVS pays higher for evaluation and management services and lower for procedures. All physicians receive reimbursement for both evaluation and management services and procedures. The effect upon the individual physician will vary depending upon how much time they spend in office-based services as compared to procedural-based services. Typically, physicians such as primary care physicians, internists, pediatricians, rheumatologists, and pulmonologists spend more time in office-based services, and physicians such as surgeons, and cardiologists spend more time in procedure-based services. Although this fee schedule is both provider and health plan based, it results in a high quality health plan for you and your families.

Your Rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (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.

- Presbyterian Health Plan (a for profit organization) is owned by Presbyterian Healthcare Services (a non-profit organization), which has been providing quality care for New Mexicans since 1908.
- As part of Presbyterian Healthcare Services, the health plan represents an organization with over 100 years of community service to New Mexicans.
- Customer Satisfaction Measures
- Networks and Providers

If you want more information about us, call 800-356-2219, or write to Presbyterian Health Plan, P.O. Box 27489, Albuquerque, NM 87125-7489. For the hearing impaired, call our TTY line at 505-923-5699 or toll-free 1-877-298-7407. You may also contact us by fax at 505-923-8163 or visit our Web site at www.phs.org.

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.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area includes all counties of New Mexico.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office. Full-Time dependent students attending school outside Presbyterian Health Plan's service area can receive care at a Student Health Center without a preauthorization from their Primary Care Physician. Services provided outside of the Student Health Center are for medically necessary services for the initial care or treatment of an Emergency or Urgent Care situation.

Section 2 How we change for 2009

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

Changes High Option

- The copayment for chemotherapy and radiation therapy has changed from \$15 to no copayment.
- For immunosuppressive drugs following a transplant, \$1,500 per calendar year has been added to the current 15% copayment up to \$250 per prescription.
- Your share of the non-Postal will increase for Self Only or increase for Self and Family. See Back Cover.

Changes to the Standard Option

- The copayment for chemotherapy and radiation therapy has changed from \$30 to no copayment.
- For immunosuppressive drugs following a transplant, \$1,500 per calendar year has been added to the current 15% copayment up to \$250 per prescription.
- Your share of the non-Postal will increase for Self Only or increase for Self and Family. See Back Cover.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 505-923-5658 or 1-800-356-2219 or TTY for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407. You may write to us at P.O. Box 27489, Albuquerque, NM 87125 You may also request replacement cards through our Web site at www.phs.org

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and/or coinsurance.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. We obtain, verify, review, and evaluate practitioners’ competencies and qualifications on an ongoing basis to determine whether they can participate as providers in our Plan. Providers we credential include medical doctors, specialists, physician assistants, certified nurse practitioners, licensed social workers, and licensed professional counselors.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site. The listings are first organized by region within New Mexico – Central New Mexico, Northern New Mexico, and Southern New Mexico. Each region, physicians, other providers, and facilities are organized by primary care physicians are listed as family practice, general practice, internal medicine, pediatrics, and OB/GYN’s acting as PCPs.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site. The list is also on our Web site. Presbyterian Health Plan’s provider directory has a section that lists all participating facilities, hospitals, and pharmacies across the state.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You must select a primary care physician from the PHP provider directory. Locations and telephone numbers of the participating doctors are listed in the PHP provider directory or can be obtained by calling the Member Services Department 505-923-5678 or 1-800-356-2219 or TTY for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407 or by accessing our website at www.phs.org. By selecting a PCP who belongs to the plan, members are selecting their corresponding network of specialists, hospitals, and other providers to serve their healthcare needs. A PCP selection form is in your packet. Select your provider by the 5-digit provider number and mail it in the return envelope. Should you choose to change your PCP your requested change will be effective the next business day following your request.

- **Primary care**

Your primary care physician can be a family practice, general practice, internal medicine, pediatrics, and OB/GYN (if applicable) acting as a primary care physician. Your primary care physician will provide most of your health care.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one

- **Specialty care**

- You may receive specialty services from Plan physicians without a referral.
- Services of a non-Plan physician will not be covered unless precertification is obtained prior to receiving the services. You may be liable for charges resulting from failure to obtain precertification for services provided by the non-Plan physician, except for urgent or emergent services.
- If you are seeing a specialist and your specialist leaves the Plan, call us to assist You in finding another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan.

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

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

- **Hospital care**

Your primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **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 Member Services Department immediately at 1-800-356-2219 or 505-923-5678 or TTY for the hearing impaired at 505-923-5699 or 1-877-298-7407. If you are new to the FEHB Program, we will arrange for you to receive and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program 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.

- **Circumstances beyond our control**

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Consent for Use and Disclosure of Medical Records

PHP is entitled to receive from any Provider/Practitioner of services Protected Health Information (PHI) about a Member to the extent permitted by applicable law, for any permitted purpose, including but not limited to, quality assurance, utilization review, processing of claims, financial audits or other purposes related to the payment and certain healthcare operations activities of PHP. A determination of benefit coverage may be suspended pending receipt of this information. By acceptance of coverage under this agreement, the member gives consent to each provider/practitioner rendering services hereunder to disclose to PHP all information (to the extent permitted by applicable law) pertaining to the member for any permitted purpose specified in the law. This consent shall not permit a use or disclosure of PHI when an authorization is required by law or when another condition must be met for such use or disclosure to be permitted under applicable law. PHP will comply with Health Insurance Portability and Accountability Act (HIPAA) rules and regulations

Services requiring our prior approval

Certain services require approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for services such as, but not limited to: Durable Medical Equipment, Hospice, Acute Rehabilitation, Outpatient Rehab, Skilled Nursing Facilities, Hospitalization, Mental Health/Substance Abuse care and Growth hormone therapy (GHT).

Except in a medical emergency you must obtain pre-authorization prior to seeing a non-Plan physician. Your Plan physician must get our approval before sending you to a hospital. If required medical services are not available from Plan providers, your Plan physician must request and obtain written authorization from the Presbyterian Health Plan Medical Director before you may receive services.

Section 4 Your costs for covered services

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

Copayments

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 primary care physician **for non-preventive services**, you pay a copayment of \$15 per office visit and when you go see a specialist, you pay a copayment of \$25 per office visit (High Option) or \$30 per office visit and when you go see a specialist, you pay a copayment of \$40 per office visit (Standard Option). When you see your primary care physician **for preventive services**, you pay a copayment of \$10 per office visit and when you go see a specialist, you pay a copayment of \$15 per office visit (High Option) or \$15 per office visit (Standard Option). When you go in the hospital, you pay \$200 facility copayment per admission (High Option) or \$500 facility copayment per admission (Standard Option).

Cost-sharing

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

Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 50% of our allowance for infertility services and 30% of our allowable for durable medical equipment.

Your catastrophic protection out-of-pocket maximum

After your (copayments and coinsurance) total \$2000 per person or \$4000 per family enrollment in any Calendar year, You do not have to pay any more for Covered services. However, copayments and/or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- Prescription drugs
- Dental services
- Vision services
- Non-covered charges

Be sure to keep accurate records of your copayments and/or coinsurance since you are responsible for informing us when you reach the maximum.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to see 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.

Section 5 High and Standard Option Benefits

See page 9 for how benefits changed this year. Page 73 and page 74 are a benefits summary of each option. Make sure you review the benefits that are available in which you are enrolled.

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Section 5 High and Standard Option Benefits Overview

This Plan offers both a High and Standard Option. Both benefit packages are described in Section 5. Make sure that you review the benefits that are available under the option in which you are enrolled.

The High and Standard Option Section 5 is divided into subsections. Please read the *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 filling advice, or more information about High and Standard Option benefits, contact us by calling the Member Services Department 505-923-5678 or 1-800-356-2219 or TTY for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407 or by accessing our website at www.phs.org.

Each option offers unique features.

<p>High Option</p> <p>The High Option covers most services subject to a copayment. See Section 5 for plan specifics.</p>	
<p>Standard Option</p> <p>We also offer a Standard Option plan. With the Standard Option plan, your copayments may be higher than the High Option, but your premium is lower. See Section 5 for plan specifics.</p>	

**Section 5(a) Medical services and supplies
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.
- Plan physicians must provide or arrange your care.
- We have no Calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Diagnostic and treatment services	High Option	Standard Option
Professional services of physicians <ul style="list-style-type: none"> • Primary Care Physician • Specialist 	\$15 copayment per visit \$25 copayment per visit (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)	\$30 copayment per visit \$40 copayment per visit (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • Office medical consultation • Second surgical opinion • In a Skilled Nursing Facility: Admission must be arranged and preauthorized by the Plan. Skilled Nursing Facility care is provided for up to 60 days per member, <i>per Calendar year</i> 	\$15 copayment for participating providers \$25 copayment for non-participating providers \$100 copayment per visit (outpatient) (included in hospital/facility outpatient copayment) \$15 copayment per visit to primary care physician \$25 copayment per visit to specialist \$15 copayment per visit to primary care physician \$25 copayment per visit to specialist \$200 copayment per admission (Physician charges are included in the inpatient hospital/facility admission copayment)	\$30 copayment for participating providers \$40 copayment for non-participating providers \$150 copayment per visit (outpatient) (included in hospital/facility outpatient copayment) \$30 copayment per visit to primary care physician \$40 copayment per visit to specialist \$30 copayment per visit to primary care physician \$40 copayment per visit to specialist \$500 copayment per admission (Physician charges are included in the inpatient hospital/facility admission copayment)

Diagnostic and treatment services - continued on next page

Benefit Description	You pay	
Diagnostic and treatment services (cont.)	High Option	Standard Option
At home	\$15 copayment per visit by a primary care physician \$25 copayment per visit by a specialist	\$30 copayment per visit by a primary care physician \$40 copayment per visit by a specialist
Lab, X-ray and other diagnostic tests	High Option	Standard Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG Computed Axial Tomography (CAT) scans/ Magnetic Resonance Imaging (MRI) tests/ Positron Emission Topography (PET) scans Sleep Studies – Outpatient overnight stay without admission Sleep Studies – Outpatient overnight stay with admission	Diagnostic tests are not subject to a copayment regardless of whether an office visit is billed. If an office visit is billed, the following copayments are taken: \$15 copayment per visit to primary care physician \$25 copayment per visit to specialist \$50 copayment per test \$50 copayment per test \$200 copayment per admission	Diagnostic tests are not subject to a copayment regardless of whether an office visit is billed. If an office visit is billed, the following copayments are taken: \$30 copayment per visit to primary care physician \$40 copayment per visit to specialist \$50 copayment per test \$50 copayment per test \$500 copayment per admission
Preventive care, adult	High Option	Standard Option
Routine screenings, such as: Preventive physical exam Office based health education Glaucoma testing Family planning Blood lead level - one annually <ul style="list-style-type: none"> • Total Blood Cholesterol - once every three years • Osteoporosis Screening • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 Routine screenings, such as:	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment. \$10 copayment per visit to primary care physician	\$15 copayment per visit to primary care physician \$30 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment. \$15 copayment per visit to primary care physician

Benefit Description	You pay	
Preventive care, adult (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Chlamydia infection 	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment.	\$15 copayment per visit to primary care physician \$30 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment.
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment	\$15 copayment per visit to primary care physician \$30 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment
Routine Pap test Human papillomavirus screening – every three years starting at age 30 Note: The office visit is covered if pap test or human papillomavirus screening is received on the same day, see <i>Diagnostic and treatment services</i> , above.	\$10 copayment per visit to primary care physician \$15 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment.	\$15 copayment per visit to primary care physician \$30 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment.
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> From age 35 through 39, one during this five year period From age 40 through 64, one every calendar year At age 65 and older, one every two consecutive calendar years 	You pay nothing for mammograms. Additional mammograms are covered when a Plan provider determines that they are medically necessary.	You pay nothing for mammograms. Additional mammograms are covered when a Plan provider determines that they are medically necessary.
Adult routine immunizations, endorsed by the Centers for Disease Control and Prevention (CDC):	\$10 copayment per visit to primary physician \$15 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment. (waived if nursing visit only)	\$15 copayment per visit to primary physician \$30 copayment per visit to specialist Preventive care services are included in the Preventive care office visit copayment. (waived if nursing visit only)
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>	<i>All charges</i>

Benefit Description	You pay	
Preventive care, children	High Option	Standard Option
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	<p>\$10 copayment per visit to primary care physician</p> <p>\$15 copayment per visit to specialist</p> <p>Preventive care services are included in the Preventive care office visit copayment</p> <p>(waived if nursing visit only)</p>	<p>\$15 copayment per visit to primary care physician</p> <p>\$30 copayment per visit to specialist</p> <p>Preventive care services are included in the Preventive care office visit copayment</p> <p>(waived if nursing visit only)</p>
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	<p>\$10 copayment per visit to primary care physician</p> <p>\$15 copayment per visit to specialist</p> <p>Preventive care services are included in the Preventive care office visit copayment.</p> <p>(immunizations waived if nursing visit only)</p>	<p>\$15 copayment per visit to primary care physician</p> <p>\$30 copayment per visit to specialist</p> <p>Preventive care services are included in the Preventive care office visit copayment.</p> <p>(immunizations waived if nursing visit only)</p>
Maternity care	High Option	Standard Option
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page 11 for other circumstances, such as extended stays for you or your baby. You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. 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 and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$15 copayment per visit up to a maximum of \$150 per pregnancy</p> <p>Specialists (Perinatologist) - \$25 copayment per visit</p> <p>Delivery – Inpatient - \$200 copayment per admission (included in inpatient hospital/facility inpatient admission copayment)</p>	<p>\$30 copayment per visit up to a maximum of \$300 per pregnancy</p> <p>Specialists (Perinatologist) - \$40 copayment per visit</p> <p>Delivery – Inpatient - \$500 copayment per admission (included in inpatient hospital/facility inpatient admission copayment)</p>

Benefit Description	You pay	
Maternity care (cont.)	High Option	Standard Option
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p> <p><i>Circumcisions performed other than during the newborn Hospital stay are only Covered when Medically Necessary.</i></p>	<i>All charges</i>	<i>All charges.</i>
Family planning	High Option	Standard Option
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives (Such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>Outpatient – \$100 copayment per visit (included in hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in Hospital/facility admission copayment)</p> <p>Insertion procedure only: 50% of all charges</p> <p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>No additional copayment if office visit copayment is already taken. 50% of all charges</p> <p>50% of all charges</p> <p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>No additional copayment if office visit copayment is already taken.</p>	<p>Outpatient – \$150 copayment per visit (included in hospital/facility outpatient copayment)</p> <p>Inpatient - \$500 copayment per admission (included in Hospital/facility admission copayment)</p> <p>Insertion procedure only: 50% of all charges</p> <p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>No additional copayment if office visit copayment is already taken. 50% of all charges</p> <p>50% of all charges</p> <p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>No additional copayment if office visit copayment is already taken.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<i>All charges.</i>	<i>All charges.</i>
Infertility services	High Option	Standard Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: • intravaginal insemination (IVI) • intracervical insemination (ICI) • intrauterine insemination (IUI) <p>Artificial insemination is covered up to 3 inseminations.</p> <ul style="list-style-type: none"> • Fertility drugs 	<p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>50% of all charges</p> <p>50% of all charges</p>	<p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>50% of all charges</p> <p>50% of all charges</p>

Infertility services - continued on next page

Benefit Description	You pay	
Infertility services (cont.)	High Option	Standard Option
<p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefits</p>	50% of all charges	50% of all charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> • <i>in vitro fertilization</i> • <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg.</i> 	<i>All charges.</i>	<i>All charges</i>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections • Allergy serum 	<p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>Allergy injections are included in the office visit copayment. If there is no office visit, allergy injections are not subject to a copayment.</p> <p>(waived if nursing visit only) Nothing</p>	<p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>Allergy injections are included in the office visit copayment. If there is no office visit, allergy injections are not subject to a copayment.</p> <p>(waived if nursing visit only) Nothing</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<i>All charges.</i>	<i>All charges.</i>
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 33.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Chemotherapy • Specialty Pharmaceuticals (see also Home health services) – Oral or inhalation forms/ Self-administered 	<p>Nothing</p> <p>\$25 copayment per visit to specialist</p> <p>Nothing.</p> <p>15% copayment up to a maximum of \$250 per prescription and \$1,500 per Calendar Year</p>	<p>Nothing</p> <p>\$40 copayment per visit to specialist</p> <p>Nothing.</p> <p>15% copayment up to a maximum of \$250 per prescription and \$1,500 per Calendar Year</p>

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Specialty Pharmaceuticals – Intravenous (IV) • Growth hormone therapy (GHT) <p>Note: – We only cover GHT when we preauthorize the treatment. Growth Hormone is covered for children with growth potential who have total or partial growth hormone deficiency (idiopathic or organic). The diagnosis of growth hormone deficiency must be confirmed by at least two stimulation tests. Growth hormone injections are specifically excluded in member’s with Turner’s syndrome or Down’s syndrome, unless growth hormone deficiency can be documented, and when preauthorized by us. For adults, growth hormone is covered only for non-functioning or surgically removed pituitary glands with demonstrated low levels of growth hormone. Growth hormone injections are excluded for chronic renal failure or other chronic disease regardless of stimulated growth hormone levels.</p> <p>We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3. Continuation of therapy using any drug is dependent upon its demonstrable efficacy.</p>	<p>15% copayment up to a maximum of \$250 per prescription and \$1,500 per Calendar Year</p> <p>Nothing.</p>	<p>15% copayment up to a maximum of \$250 per prescription and \$1,500 per Calendar Year</p> <p>Nothing.</p>
Physical and occupational therapies	High Option	Standard Option
<p>Provided in patient or out-patient up to 2 months per condition if significant improvement is expected for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists; and • occupational therapists. 	<p>\$25 copayment per visit</p>	<p>\$40 copayment per visit</p>

Physical and occupational therapies - continued on next page

Benefit Description	You pay	
Speech therapies (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <p><i>Speech Therapy beyond 6 consecutive months.</i></p>	<i>All charges</i>	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17, which include; (see <i>Preventive care, children</i>) 	<p>\$10 copayment per visit to primary care physician</p> <p>\$15 copayment per visit to specialist</p>	<p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p>
<p><i>Not covered: All other hearing testing</i></p> <ul style="list-style-type: none"> • <i>Hearing aids batteries</i> <p><i>Hearing aids, testing and examinations for hearing aids</i></p>	<i>All charges.</i>	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	High Option	Standard Option
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>) • One Eye refraction per year for children under 6 when medically necessary to aid in the diagnosis of certain eye diseases • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	<p>\$10 copayment per visit to primary care physician</p> <p>\$15 copayment per visit to specialist</p> <p>\$10 copayment per visit to primary care physician</p> <p>\$15 copayment per visit to specialist</p> <p>30% of all charges</p>	<p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>30% of all charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 17, examinations for them</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Replacement of all items referenced in this section due to loss, neglect, theft, misuse, abuse or for convenience.</i> 	<i>All charges.</i>	<i>All charges.</i>

Benefit Description	You pay	
Foot care	High Option	Standard Option
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p>	<p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> <p><i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></p>	<p><i>All charges.</i></p>	<p><i>All charges</i></p>
Orthopedic and prosthetic devices	High Option	Standard Option
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Prosthetic devices are covered only when they replace a limb or other part of the body after accidental or surgical removal and/or when the body's growth necessitates replacement • For diabetics, Covered services include foot appliances, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment • Penile Prostheses are limited to the reasonable charge for semi-rigid or flexible rod prostheses. Benefits for inflatable penile prostheses may be provided when medically necessary. 	<p>30% of all charges</p>	<p>30% of all charges</p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Prosthetic Devices will be provided when determined to be medically necessary by the plan physician. Prosthetic devices must be preauthorized by us. 	30% of all charges	30% of all charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes</i> <i>Arch supports</i> <i>Foot orthotics</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices, except for gradient compression hose</i> <i>Prosthetic replacements provided less than 3 years after the last one we covered</i> <i>Speech synthesis devices</i> 	<i>All charges</i>	<i>All charges.</i>
Durable medical equipment (DME)	High Option	Standard Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> Hospital beds; Wheelchairs; Crutches; Walkers; Blood glucose monitors; and Insulin pumps. <p>Repair and replacement of Durable Medical Equipment, Prosthetics and Orthotics Devices is Covered when Preauthorized by PHP and when Medically Necessary due to change in the member's condition, wear or after the product's normal life expectancy has been reached.</p>	30% of all charges	30% of all charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Deluxe equipment such as motor driven wheelchairs, chair lifts, or beds, when standard equipment is available and adequate.</i> 	<i>All charges.</i>	<i>All charges.</i>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Chiropractic (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Subluxation must be documented by chiropractic examination and documented in the chiropractic records • Chiropractic x-rays are only covered when performed by a chiropractor for the following clinical situations, unless clinically relevant x-rays already exist: <ul style="list-style-type: none"> - Acute trauma with a suspected fracture, such as motor vehicle accidents or slip and fall accidents - Clinical evidence of significant osteoporosis: recent fracture of the spine, wrist or hip; loss of height over ½ inch, or spine curvature consistent with osteoporotic fractures; or - Abnormal neurologic or orthopedic findings suggesting spinal nerve impingement • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	<p>\$25 copayment per office visit</p>	<p>\$40 copayment per office visit</p>
<p><i>Not covered:</i></p> <p><i>Chiropractic treatment for chronic subluxation or rheumatoid arthritis, allergy, muscular dystrophy, multiple sclerosis, pneumonia, chronic lung disease, and other diseases/ conditions.</i></p> <p><i>Rolfing</i></p> <p><i>Massage therapy</i></p> <p><i>Naturopathic services</i></p> <p><i>Hypnotherapy</i></p>	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Alternative treatments	High Option	Standard Option
<p>Acupuncture – 20 visits per year if determined medically necessary by a doctor of medicine or osteopathy, for anesthesia, smoking cessation or chronic or acute pain</p> <p>Acupuncture treatment for other medical conditions will be covered only if the following conditions are met:</p>	<p>\$25 copayment per office visit</p>	<p>\$40 copayment per office visit</p>

Alternative treatments - continued on next page

Benefit Description	You pay	
Alternative treatments (cont.)	High Option	Standard Option
<p>There is evidence-based medical literature that clearly supports the safety, efficacy and appropriateness of this treatment for the specific medical condition for which authorization is requested</p> <p>Acupuncture must be part of a coordinated plan of care</p> <p>Biofeedback is only covered for treatment of Raynaud’s disease or phenomenon and urinary or fecal incontinence</p>	\$25 copayment per office visit	\$40 copayment per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> 	<i>All charges.</i>	<i>All charges.</i>
Educational classes and programs	High Option	Standard Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation coverage is provided for diagnostic services, cessation counseling and pharmacotherapy. Medical services are provided by licensed healthcare professionals with specific training in managing the Member’s Smoking Cessation program. 	<i>No copayment for educational classes and programs. Regular plan benefits apply to medical services and prescription drugs.</i>	<i>No copayment for educational classes and programs. Regular plan benefits apply to medical services and prescription drugs.</i>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Hypnotherapy</i> • <i>Over the counter drugs</i> • <i>Acupuncture is not covered under the Smoking Cessation Counseling benefit. However, acupuncture for smoking cessation is covered under the acupuncture benefit subject to the acupuncture copayment and benefit limitation</i> 	<i>All charges</i>	<i>All charges</i>

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.
- Plan physicians must provide or arrange your care.
- We have no Calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay	
	High Option	Standard Option
<p>Surgical procedures</p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. Note: Refer to our Web site www.phs.org for more information regarding coverage and exclusion criteria. • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 	<p>Office visit –</p> <p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in outpatient hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in inpatient hospital/facility inpatient admission copayment)</p>	<p>Office visit –</p> <p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>Outpatient - \$150 copayment per visit (included in outpatient hospital/facility outpatient copayment)</p> <p>Inpatient - \$500 copayment per admission (included in inpatient hospital/facility inpatient admission copayment)</p>

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	High Option	Standard Option
<p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>Office visit –</p> <p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in outpatient hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in inpatient hospital/facility inpatient admission copayment)</p>	<p>Office visit –</p> <p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>Outpatient - \$150 copayment per visit (included in outpatient hospital/facility outpatient copayment)</p> <p>Inpatient - \$500 copayment per admission (included in inpatient hospital/facility inpatient admission copayment)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All Charges.</i></p>	<p><i>All charges.</i></p>
Reconstructive surgery	High Option	Standard Option
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonable be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>Office visit –</p> <p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in the hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>	<p>Office visit –</p> <p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>Outpatient - \$150 copayment per visit (included in the hospital/facility outpatient copayment)</p> <p>Inpatient - \$500 copayment per admission (included in hospital/facility inpatient admission copayment)</p>

Benefit Description	You pay	
Reconstructive surgery (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> • <i>Claims incurred due to complications of elective cosmetic surgery</i> 	<p><i>All Charges.</i></p>	<p><i>All charges</i></p>
Oral and maxillofacial surgery	High Option	Standard Option
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ benefit (Limited – Please refer to Section 5(h) Dental Benefits. 	<p>Office visit –</p> <p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in the hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>	<p>Office visit –</p> <p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>Outpatient - \$150 copayment per visit (included in the hospital/facility outpatient copayment)</p> <p>Inpatient - \$500 copayment per admission (included in hospital/facility inpatient admission copayment)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
Organ/tissue transplants	High Option	Standard Option
<p>Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for precertification procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.</p> <p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung 	<p>Office visit –</p> <p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in the hospital/facility outpatient copayment)</p>	<p>Office visit –</p> <p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>Outpatient - \$150 copayment per visit (included in the hospital/facility outpatient copayment)</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Single, double, or lobar lung • Kidney • Liver • Pancreas • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas <p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Chronic myelogenous leukemia • Hemoglobinopathy (i.e. Fanconi's, Thalessemia major) • Myelogenous/Myelodysplastic syndromes • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Amyloidosis <p>Autologous transplants for</p> <ul style="list-style-type: none"> • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin’s lymphoma • Advanced non-Hodgkin’s lymphoma • Neuroblastoma • Amyloidosis <p>Autologous tandem transplants for</p> <ul style="list-style-type: none"> • Recurrent germ cell tumors (including testicular cancer) • Multiple myeloma • De-novo myeloma <p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> • Allogeneic transplants for <ul style="list-style-type: none"> - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) 	<p>Office visit –</p> <p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in the hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>	<p>Office visit –</p> <p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>Outpatient - \$150 copayment per visit (included in the hospital/facility outpatient copayment)</p> <p>Inpatient - \$500 copayment per admission (included in hospital/facility inpatient admission copayment)</p>

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Sickle cell anemia • Autologous transplants for <ul style="list-style-type: none"> - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer <p>Mini-transplants (non-myeloblastic, reduced intensity conditioning) for covered transplants: Subject to medical necessity.</p> <p>Tandem transplants for covered transplants: Subject to medical necessity</p> <p>National Transplant Program (NTP) – All organ transplants must be medically necessary. Transplants will be performed at a site approved by us</p> <ul style="list-style-type: none"> • Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute – or National Institutes of Health-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols. • Note: We cover related medical and hospital expenses of the donor when we cover the recipient. The plan will pay reasonable and customary charges for hospital, surgical, laboratory and x-ray services for a donor who is not entitled to benefits under any other health benefit plan or policy. Donor charges must result from the medically necessary covered transplant of an organ or body tissue to a member of the plan. • Limited travel benefits are available for the transplant recipient and one other person. Transportation costs will be covered only if out-of-state travel is required. Reasonable expenses for lodging and meals will be covered for both out-of-state and in-state, up to a maximum of \$150 a day for both combined. All benefits for transportation, lodging and meals are limited to a maximum of \$10,000. 	<p>Office visit –</p> <p>\$15 copayment per visit to primary care physician</p> <p>\$25 copayment per visit to specialist</p> <p>Outpatient - \$100 copayment per visit (included in the hospital/facility outpatient copayment)</p> <p>Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>	<p>Office visit –</p> <p>\$30 copayment per visit to primary care physician</p> <p>\$40 copayment per visit to specialist</p> <p>Outpatient - \$150 copayment per visit (included in the hospital/facility outpatient copayment)</p> <p>Inpatient - \$500 copayment per admission (included in hospital/facility inpatient admission copayment)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All Charges</i></p>	<p><i>All charges.</i></p>

High and Standard Option

Benefit Description	You pay	
Anesthesia	High Option	Standard Option
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	Inpatient - \$200 copayment per admission (included in hospital/facility inpatient admission copayment)	Inpatient - \$500 copayment per admission (included in hospital/facility inpatient admission copayment)
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist Outpatient - \$100 copayment per visit (included in the hospital/facility outpatient copayment)	\$30 copayment per visit to primary care physician \$40 copayment per visit to specialist Outpatient - \$150 copayment per visit (included in the hospital/facility outpatient copayment)

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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no Calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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).

YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$200 copayment per admission	\$500 copayment per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen 	\$200 copayment per admission	\$500 copayment per admission
<ul style="list-style-type: none"> • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. 	\$200 copayment per admission	\$500 copayment per admission
Not covered: <ul style="list-style-type: none"> • Custodial care 	All Charges	All charges

Inpatient hospital - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital (cont.)		
<ul style="list-style-type: none"> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care, except when medically necessary</i> 	<i>All Charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center		
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • 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 • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$100 copayment per visit	\$150 copayment per visit
Extended care benefits/Skilled nursing care facility benefits		
<p>Skilled nursing facility (SNF): 60 days per member per Calendar year</p> <p>Note: We cover Room and board and other necessary services that you require and a SNF provides. The Plan must preauthorize the services that your Plan physician recommends</p>	\$200 copayment per admission	\$500 copayment per admission
<i>Not covered: Custodial care or domiciliary care</i>	<i>All Charges.</i>	<i>All charges.</i>
Hospice care		
<p>The following services are covered for in-patient and in-home hospice benefits</p> <ul style="list-style-type: none"> • Inpatient hospice care • Physician visits by plan hospice physicians • Home health care by approved home health care personnel • Physical therapy • Medical supplies • Drugs and medication for the terminally ill patient 	\$200 copayment per admission (included in hospital/facility inpatient admission copayment)	\$500 copayment per admission (included in hospital/facility inpatient admission copayment)

Hospice care - continued on next page

Benefit Description	You pay	
Hospice care (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> Respite care for a period not to exceed five continuous days for every 60 days of hospice care. Only two respite cares are available during a hospice benefit period <p>Benefits are provided for in a Plan hospice or facility approved by the plan physician and preauthorized by the plan.</p> <p>The hospice benefit period must begin while you are covered with this benefit, and coverage through the plan must be continued throughout the benefit period in order for hospice benefits to continue.</p> <p>The hospice benefits period is defined as:</p> <p>Beginning on the date the plan physician certifies that you are terminally ill with a life expectancy of six months or less; and ending six months after it began, or upon death.</p> <p>If you require an extension of the hospice benefit period, the hospice must provide a new treatment plan and the plan physician must recertify your medical condition to us. No more than one additional hospice benefit period will be preauthorized by us.</p>	<p>\$200 copayment per admission (included in hospital/facility inpatient admission copayment)</p>	<p>\$500 copayment per admission (included in hospital/facility inpatient admission copayment)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Food, housing and delivered meals</i> <p>Volunteer services Comfort items Homemaker and housekeeping services Private duty nursing <i>Pastoral and spiritual counseling and Bereavement counseling</i></p>	<p><i>All Charges</i></p>	<p><i>All charges</i></p>
Ambulance	High Option	Standard Option
Local professional ambulance service when medically appropriate	\$50 copayment per occurrence	\$50 copayment per occurrence
Ground Ambulance	\$100 copayment per occurrence	\$100 copayment per occurrence
Air ambulance	\$100 copayment per occurrence	\$100 copayment per occurrence

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.
- We have no Calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

If you need emergency care you should call 911 or seek treatment at the nearest emergency room. If in need of urgent care, you should seek treatment at an urgent care center that is open and available for business. Please note that some urgent care centers are not open after 8:00 p.m. In such circumstances, you may need to use an emergency room for care that is needed on an urgent basis.

Acute emergency medical care is covered 24 hours per day, seven days per week for services needed immediately to prevent jeopardy to your health. If you cannot reasonably access a plan facility, we will make arrangements to cover your care that is needed on an urgent basis.

Coverage for services will continue until you are medically suitable, do not require critical care, and can be safely transferred to a hospital in our plan network.

We will provide reimbursement when you, acting in good faith, obtain emergency care for what appears to you acting as a reasonable lay person, to be an acute condition that requires immediate medical attention, even if your condition is subsequently determined to be non-emergent.

In determining whether you acted as a “reasonable layperson” we determine the following factors:

- Your belief that the circumstances required immediate medical care that could not wait until the next working day or the next available appointment
- The time of day the care was provided
- The presenting symptoms
- Any circumstances that prevented you from using our established procedures for obtaining emergency care

We will not deny a claim for emergency care when you are preauthorized to the emergency room by a plan doctor or the plan.

No prior preauthorization is required for emergency care.

If your emergency care results in a hospitalization directly from the emergency room the emergency co-payment is waived.

Emergencies within our service area

You should seek medical treatment from Plan providers whenever possible. Follow up care from Plan or non-Plan providers within the service area requires a preauthorization from a Plan provider.

Out-of-network emergency care will be provided to you without additional cost. The reasonable lay person standard from above will apply to determine if out of network care was appropriate.

Emergencies outside our service area

You may seek services from the nearest facility where emergency treatment can be provided. Non-emergent follow up care outside the service area is not covered unless transfer to a Plan provider would be medically inappropriate and a risk to your health. Non-emergent follow-up care outside of our service area is not covered for convenience or preference.

Benefit Description	You pay	
Emergency within our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$15 copayment per visit to primary care physician	\$30 copayment per visit to primary care physician
<ul style="list-style-type: none"> Professional services of physician 	\$25 copayment per visit to specialist \$15 copayment per visit for participating providers	\$40 copayment per visit to specialist \$30 copayment per visit for participating providers
In an urgent care center	\$25 copayment per visit for non-participating providers	\$40 copayment per visit for non-participating providers
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$75 copayment per visit	\$100 copayment per visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>	<i>All charges.</i>
Emergency outside our service area	High Option	Standard Option
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$15 copayment per visit to primary care physician	\$30 copayment per visit to primary care physician
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$25 copayment per visit to specialist \$25 copayment per visit for non-participating providers	\$40 copayment per visit to specialist \$40 copayment per visit for non-participating providers
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$75 copayment per visit	\$100 copayment per visit
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All Charges.</i>	<i>All charges.</i>
Ambulance	High Option	Standard Option
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.		
<ul style="list-style-type: none"> Ground ambulance Air ambulance 	\$50 copayment per occurrence \$100 copayment per occurrence	\$50 copayment per occurrence \$100 copayment per occurrence
Inter-Facility Transfer:		

Ambulance - continued on next page
High and Standard Option Section 5(d)

High and Standard Option

Benefit Description	You pay	
Ambulance (cont.)	High Option	Standard Option
<ul style="list-style-type: none">• Ground Ambulance• Air Ambulance	Nothing \$100 copayment per occurrence	Nothing \$100 copayment per occurrence
<i>Not covered: Inter-Facility Transfer Services if not preauthorized</i>	<i>All Charges.</i>	<i>All charges.</i>

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay	
	High Option	Standard Option
<p>Mental health and substance abuse benefits</p> <p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$25 copayment per visit</p>	<p>\$40 copayment per visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing if received during the office visit or inpatient hospital admission; otherwise applicable physician visit copayment</p>	<p>Nothing if received during the office visit or inpatient hospital admission; otherwise applicable physician visit copayment</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$200 copayment per admission</p>	<p>\$500 copayment per admission</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All Charges.</i></p>	<p><i>All charges.</i></p>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
	<i>All Charges.</i>	<i>All charges.</i>
Preauthorization	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <p>To access mental health services, simply contact the Presbyterian Health Plan Behavioral Unit at 505-923-5470 or 1-800-453-4347. The behavioral health provider is responsible for any preauthorizations.</p>	
Limitation	We may limit your benefits if you do not obtain a treatment plan.	

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 the chart beginning on the next page.
- 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.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A Plan provider must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a plan pharmacy, (except for out-of-area emergencies), or by mail for a maintenance medication. Mail order medications are available through the Mail Service Pharmacy. You may obtain the name of the Mail Service Pharmacy by calling Member Services at 505-923-5678 or 1-800-356-2219. Order forms are available from the Plans's customer service department.
- **We use a Preferred List.** We cover non-preferred drugs prescribed by a Plan doctor. Prescription medications are prescribed by a Plan provider and dispensed in accordance with the Plan's Preferred List. The Preferred List is a list of generic and brand name medications that we selected to meet patient needs for quality treatment at a lower cost. You may request a copy of this Preferred List by calling Member Services at 1-800-356-2219 or 505-923-5678. An on-line version of our Preferred List is also available at our web site – www.phs.org (click on Health Plans, Pharmacy, Member and Commercial Group 4-Tier Formularies).
- We have an open Preferred listing. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a Preferred list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call Member Services at 505-923-5678 or 1-800-356-2219. An on-line version of our Preferred List is available on our web site – www.phs.org (click on Health Plans, Pharmacy, Member and Commercial Group 4-Tier Formularies).
- Prescription medications prescribed by a Plan provider and obtained at a Plan pharmacy will be dispensed for up to a 30 day supply up to the maximum dosing recommended by the manufacturer, or one commercially prepackaged unit i.e. one inhaler, one vial ophthalmic drops, one vial of insulin). Any amount of medication beyond these quantity limits, even if necessary to obtain a months supply, will be associated with multiple copayments (for example, 200 tablets of a medication or 2 prepackaged inhalers, necessary for a months supply, will be associated with payment of two copayments for that medication)
- Maintenance medications purchased through the mail order option will be for a 90-day supply up to the maximum dosing recommended by the manufacturer, or 3 commercially prepackaged units. Specialty Pharmaceuticals are not available through the mail order option. If you or your healthcare provider request a brand name drug in place of the generic, you pay the difference in price between the brand and generic, plus the applicable generic copayment.
- You have the option to purchase a 90-day supply of maintenance medications at a Plan pharmacy. Under the 90-day at retail pharmacy benefit, Preferred and Non-preferred maintenance medications can be obtained from a Plan pharmacy. You will be charged one of the three applicable copayments for a 90-day supply up to the manufacturer's usual maximum recommended dosing for the medication.
- Over-the-counter (OTC) medications if it is a cost-effective option, a prescription is required for approved OTC medications and is subject to the generic (Preferred) copayment. Approved OTC medications are subject to changes as determined by the Plan.

- If a medication qualifies for the voluntary tablet-splitting program, you have the option of having the pharmacist cut the higher strength tablet in half. If you participate in the tablet-splitting program, your copayment will be half of your regular copayment. For example, if your copayment is \$20, under the program you would pay only \$10. Talk with your pharmacist if you wish to take advantage of the tablet-splitting program and they will perform the tablet splitting for you. To locate approved medications for tablet-splitting, call Member Services at 505-923-5678 or 1-800-356-2219. An on-line list of approved medications for tablet-splitting is available on our web site – www.phs.org (click on Health Plans, Pharmacy, Member and Pharmacy Utilization Controls).
- **These are the dispensing limitations.**

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

Prescription refill requests through a Plan pharmacy or the mail order option will be processed at or near the expected time at which the original supply of medication would be exhausted. Requests for early refills can be made to the Plan pharmacy, who can then request approval from the Plan. Replacement prescriptions resulting from loss, theft, or destruction are not a covered benefit.

Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications, should call our Member Services Department at 505-923-5678 or 1-800-356-2219.

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written or the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

Why use generic drugs? Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your Plan less money than a name-brand drug.

When you do have to file a claim.

In-Network

Claims' filing is not necessary. You are responsible for paying the copayment or coinsurance.

Out-of-network

For services provided by out-of-network providers, you may be required to file a claim if the provider does not do so. To file a claim, complete all questions on the claim form (see sample), sign it, and attach an itemized statement from the provider. Be sure the statement includes all of the following:

Patient's Name

Diagnosis

Date of Service

Procedure Code

Price for each procedure

Name and address of the provider.

A separate claim form is required for each family member.

If the provider's office uses a universal claim form (HCFA-1500), that form may be submitted in lieu of the Presbyterian Health Plan claim form as long as the patient and insured information is completed.

If a charge is made to you for covered pharmacy benefits, you must provide proof of such charge with a copy of the pharmacy receipt with the name of the drug, quantity dispensed, and National Drug Code (NDC) number. Any charge shall be paid only upon receipt of proof satisfactory to the Plan of the occurrence, character and extent of the event and services for which claim is made.

Mail proof to:

Presbyterian Health Plan

Attention: Pharmacy

P.O. Box 27489

Albuquerque, NM87125-7489

Benefit Description	You pay	
Covered medications and supplies	High Option	Standard Option
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Smoking Cessation (limited to two (2) 90-day courses of treatment per Calendar year) • Insulin • Diabetic supplies including insulin syringes, needles, blood test strips, urine test tape, and acetone test tablets. (Glucose monitors are covered as durable medical equipment, see under Durable Medical Equipment section) • All FDA-approved oral and injectable contraceptive drugs and contraceptive devices • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction when preauthorized by Us • Contraceptive drugs and devices 	<p>\$10 copayment per generic (Preferred) – 30 day supply up to the maximum dosing recommended by the manufacturer</p> <p>\$20 copayment per brand (Preferred) – listed on the PHP Preferred List – 30 day up to the maximum dosing recommended by the manufacturer</p> <p>\$40 copayment Non-preferred – 30 day supply up to the maximum dosing recommended by the manufacturer</p> <p>Mail order</p> <p>\$20 copayment per generic (Preferred) – 90 day supply up to the maximum dosing recommended by the manufacturer</p> <p>\$40 copayment per brand (Preferred) – listed on the PHP Preferred List – 90 day supply up to the maximum dosing recommended by the manufacturer</p> <p>\$80 copayment Non-preferred – 90 day supply up to the maximum dosing recommended by the manufacturer</p>	<p>\$15 copayment per generic (Preferred) – 30 day supply up to the maximum dosing recommended by the manufacturer</p> <p>\$35 copayment per brand (Preferred) – listed on the PHP Preferred List – 30 day up to the maximum dosing recommended by the manufacturer</p> <p>\$55 copayment Non-preferred – 30 day supply up to the maximum dosing recommended by the manufacturer</p> <p>Mail order</p> <p>\$30 copayment per generic (Preferred) – 90 day supply up to the maximum dosing recommended by the manufacturer</p> <p>\$70 copayment per brand (Preferred) – listed on the PHP Preferred List – 90 day supply up to the maximum dosing recommended by the manufacturer</p> <p>\$110 copayment Non-preferred – 90 day supply up to the maximum dosing recommended by the manufacturer</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Fertility drugs, oral or injectable, including those provided in a physician's office • Specialty Pharmaceuticals <ul style="list-style-type: none"> - Oral or inhalation forms/Self-administered - Intravenous (IV) - Immunosuppressive drugs following transplant surgery 	<p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay 50% of all charges</p> <p>15% copayment up to a maximum of \$250 per prescription and \$1,500 per Calendar Year Nothing</p> <p>15% copayment up to a maximum of \$250 per prescription (Subject to lifetime transplant maximum)</p>	<p>Note: If there is no generic equivalent available, you will still have to pay the brand name copayment 50% of all charges</p> <p>15% copayment up to a maximum of \$250 per prescription and \$1,500 per Calendar Year Nothing</p> <p>15% copayment up to a maximum of \$250 per prescription (Subject to lifetime transplant maximum)</p>
<ul style="list-style-type: none"> • Special Medical Foods are covered when prescribed by a physician for treatment for Genetic Inborn Errors of Metabolism, when used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status, when you are under the physician's ongoing care and when preauthorized by Us. 	50% copayment	50% copayment
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements that can be purchased without a prescription</i> • <i>Replacement prescriptions resulting from loss, theft, or destruction</i> • <i>Drugs from which there is a nonprescription equivalent available</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Nonprescription medicines</i> • <i>Special Medical Foods are not for use by the general public and may not be available in stores or supermarkets. Special Medical Foods are not those foods included in a health diet intended to decrease the risk of disease, such as reduced-fat foods, low sodium foods, or weight loss products. Special Medical Foods are not covered for conditions that are not present at birth.</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5(g) Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental and Vision Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- We have no Calendar year deductible.
- 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. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay	
	High Option	Standard Option
Accidental injury benefit We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist	\$30 copayment per visit to primary care physician \$40 copayment per visit to specialist
Dental benefits (Limited) Limited dental services will be provided. Services include, but are not limited to, the following: <ul style="list-style-type: none"> • Oral surgery medically necessary to treat infections or abscess of the teeth that involve the fascia or have spread beyond the dental space. • Removal of infected teeth in preparation for certain surgeries or radiation therapy of the head and neck. Temporomandibular Joint Disorders (TMJ) The treatment of Temporomandibular Joint disorders (TMJ) are subject to the same conditions and limitations as are applicable to treatment of any other joint in the body. Orthodontics are not covered unless the TMJ disorder is the result of an injury. (See also Oral and Maxillofacial surgery Section 5(a).	\$15 copayment per visit to primary care physician \$25 copayment per visit to specialist	\$30 copayment per visit to primary care physician \$40 copayment per visit to specialist

Section 5(h) Special features

Feature	Description
<p>Flexible benefits option</p>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative benefit, we will ask you to sign an alternative benefits agreement that will include all of the following terms. 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 cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • 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 benefits will resume if we do not approve your request. <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
<p>24 hour nurse line</p>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-905-3282 and talk with a registered nurse who will discuss treatment options and answer your health questions. The Nurse Advice Line is confidential. You will be asked to provide some basic information to ensure that you are part of the Presbyterian Health Plan. There is no limit to the number of calls you can make.</p>
<p>Services for deaf and hearing impaired</p>	<p>Contact Member Services at 505-923-5699 or toll-free at 1-877-298-7407</p>
<p>Pregnancies (Including High-Risk pregnancies)</p>	<ul style="list-style-type: none"> • PRESious Beginnings is a statewide program that determines high-risk pregnancies and offers care management, literature and use of videos. Peri-Natal nurses are available for questions Monday through Friday 8:30 a.m. to 5:00 p.m. to assist with high-risk pregnancy questions. For additional information, call 505-724-6500 • Doula services are available for Members who deliver at Presbyterian Hospital. For more information, call 505-724-6500.
<p>Presbyterian Healthcare Services</p>	<p>Presbyterian Health Services offers several health improvement classes to Presbyterian Health Plan members and the general public. Fees vary according to status of participant. Visit our website at www.phs.org or call Member Services at 505-923-5678 or toll-free at 1-800-356-2219 or for the hearing impaired 505-923-5699 or toll-free 1-877-298-7407.</p>
<p>Vision discounts</p>	<p>The Access Plan available through Vision Service Plan (VSP) offers vision services at discounted rates through VSP providers. Please refer to the Presbyterian Value Added flyer for more details or visit www.vsp.com for further information.</p>
<p>Acupuncture, Chiropractic, Massage Therapy, Meals on Wheels, Fitness Center, Vision and Hearing Hardware discounts</p>	<p>Discounted services are available through Benefit Source and their contracted providers. Please refer to the Presbyterian Value Added flyer or visit www.benefitsource.org for further details.</p>

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or 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 505-923-5678 or visit their website at www.phs.org.

- **Federal Dual Choice Dental Option** – The DentalSource Companion Plan is offered in conjunction with DentalSource and is available to Presbyterian Federal Health Plan Members. **Federal employees now have the choice of three dental plans being offered.** First is the comprehensive DentalSource Companion Indemnity Option, which offers federal employees the freedom to use any dentist of their choice. The second option provides an extremely affordable, comprehensive dental program through a network of dentists. The third option is an Indemnity Plan offered through Companion Life Insurance Company.

Indemnity Federal Plan (see any dentist)

DentalSource / Companion Indemnity Federal Plan is a fee for service dental plan that enables you and your family to see any licensed dentist in the world. The plan provides 100% coverage for Preventive Services, 80% coverage for Basic Services and 50% for Major Services. A waiting period applies to major services. The plan has a \$100 lifetime deductible (once it is paid, it never has to be paid again) and a Calendar year maximum of \$1000 per member.

Referral Plan

DentalSource Sandia Plan is a referral dental option available to Presbyterian Federal Health Plan Members. DentalSource Sandia Plan features no deductibles, no Claims Forms, no Waiting Periods, no Maximums, and no Pre-existing Condition Exclusions. This comprehensive plan provides reduced out of pocket costs for preventive and diagnostic services, fillings, crowns, and dentures, oral surgery, root canals, gum surgery, and braces for adults and children. Members select a dentist of their choice from a list of participating dentists throughout the community. A dental fee schedule lists each dental procedure with a specific fee, which is paid at the time dental services are received.

For additional information and customer service call:

Albuquerque Area: (505) 237-1501

Outside Albuquerque: 1-888-862-8659

Indemnity Plan through Companion Life Insurance Company

DentalSource now provides an Indemnity Plan through Companion Life Insurance Company. This plan offers Presbyterian Federal Employees the freedom to use any dentist of their choice. The plan has a \$1000 Annual Maximum and a \$100 Lifetime deductible per person. Presbyterian Federal Members may only enroll during the Federal Open Enrollment Season. Only Presbyterian Federal Employees new hires may enroll after the dental open season has closed and must do so within the first 60 days of employment.

- Value Added Vision Discount

Exams – 20%

Glasses – 20% off

Contact Lens Exam (Fitting and Evaluation) – 15% off

Laser Surgery (Lasik and PRK) – Average 15% - 20% off

Presbyterian members must use a VSP provider to receive a discount. Discounts are only available through the VSP doctor who provided an eye exam within the last 12 months. To find a VSP provider near you, log on to VSP's website at www.vsp.com or call VSP's Member Services at 1-800-877-7195.

Section 6 General exclusions – things we don't 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 your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition** (see specifics regarding transplants).

We do not cover the following:

- Care by non-plan providers except for authorized services or emergencies (see *Emergency services/accidents*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service; or
- Travel expenses.

Section 7 Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment or coinsurance.

You will only need to file a claim when you receive emergency services from non-Plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 505-923-5678 or toll-free at 1-800-356-2219 or for the hearing impaired at 505-923-5699 or toll-free at 1-877-298-7407.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.
- For emergency or urgent care services outside the United States you are responsible for ensuring that claims are appropriately translated and that the monetary exchange, on the date of service, is clearly identified when submitting claims.

Submit your claims to:

Presbyterian Health Plan
P.O. Box 27489
Albuquerque, NM 87125-7489

Prescription drugs

If a charge is made to you for covered pharmacy benefits, you must provide proof of such charge with a copy of the pharmacy receipt with the name of the drug, quantity dispensed, and National Drug Code (NDC) number. Any charge shall be paid only upon receipt of proof satisfactory to the Plan of the occurrence, character and extent of the event and services for which claim is made.

Submit your claims to:

Presbyterian Health Plan
Attn: Pharmacy
P.O. Box 27489
Albuquerque, NM 87125-7489

Deadline for filing your claim

Send us all of 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, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

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.

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: P.O. Box 27489 Albuquerque, NM 87125-7489 ; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

- 3** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

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.

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.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-356-2219 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **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.

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. Your care must continue to be authorized by your Plan PCP, or precertified as required.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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 payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800/356-2219 or see our Web site at www.phs.org.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **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 health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) 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 the Presbyterian Senior Care Medicare Advantage Plan for FEHBP and also remain enrolled in the Presbyterian Health Plan's FEHBP Commercial Plan. The Presbyterian Senior Care Medicare Advantage Plan will be primary and the Presbyterian Health Plan's FEHBP Commercial plan will have coverage for prescription drugs. So, if you are enrolled in Medicare Part D, the Presbyterian Health Plan FEHBP Commercial plan will coordinate your prescription drug coverage with Medicare Part D. You must select a primary care provider from the Presbyterian Senior Care Plan, however, referrals are not required for network specialists, except for: Podiatry; Otolaryngology (Ear, Nose, and Throat); Occupational, Physical and Speech/Language Therapies. Presbyterian Senior Care and Presbyterian Health Plan's FEHBP Commercial plan will coordinate your medical benefits.

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

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

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

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

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

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation 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 payer before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFED.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket costs.

Section 10 Definitions of terms we use in this brochure

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.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 9.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 9.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., coinsurance and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care provided primarily for maintenance of the patient and designed essentially to assist in meeting the patient's daily activities. It is not provided for its therapeutic value in the treatment of an illness, disease, accidental injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, and supervision over self-administration of medication not requiring the constant attention of trained medical personnel.
Experimental or investigational service	The plan evaluates any new procedures, drug therapies, treatments, devices, etc. to determine if they are Experimental/investigational in nature. This evaluation includes review of current literature published in peer review journals and appropriate information from governmental regulatory bodies, such as the FDA. We also utilize reliable evidence (consensus of opinion in the medical community) to determine if the procedure, drug therapies, treatments, devices, etc. is contraindicated for the particular indication which it has been prescribed. Please contact the plan for a more detailed explanation of this evaluation process.
Medical necessity	Appropriate or necessary services as determined by our plan doctor in consultation with the plan, which are given to you for any covered condition requiring, according to generally accepted principles of good medical practice, the diagnosis or direct care and treatment of an illness, injury, or medical condition, and are not services provided only as a convenience.
Plan allowance	Plan allowance is the amount we use to determine our payment and your Coinsurance for Covered services. Plans determine their allowances in different ways. We determine our allowance as follows: Total allowable charges for plan providers may not exceed the amount the provider service and the non-plan providers, the total allowable charges may not exceed the Plan allowance as determined by the plan for a service.
Us/We	Us and We refer to Presbyterian Health Plan.
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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

Children's Equity Act

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- 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 and Family 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 and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

When FEHB coverage ends

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

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

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of 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.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, 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, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions.

These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary BEFORE taxes are withheld, then incur eligible expenses and get reimbursed. You pay less taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program has no pre-existing condition limitations. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with up to a 24-month waiting period.

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan’s website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877-889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a serve cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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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 Presbyterian Health Plan - 2009

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: Primary Care Physician \$15 Specialist \$25 (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)	17
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	Limited benefit. Applicable physician visit copayment	49
Vision care		
	30% of all charges (materials) Applicable physician visit copayment (eye exam for children).	25
Special features: Flexible benefits option; Services for deaf and hearing impaired, pregnancies, Presbyterian Healthcare Services, vision, acupuncture, chiropractic, massage therapy, meals on wheels, fitness center, vision and hearing hardware discounts		
		50
Protection against catastrophic costs (your out-of-pocket maximum):		
	Nothing after \$2,000/Self Only or \$4,000/ Family enrollment per year Some costs do not count toward this protection	13

Summary of benefits for the Standard Option of the Presbyterian Health Plan - 2009

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Standard Option Benefits	You Pay	You Pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: Primary Care Physician \$30 Specialist \$40 (Waived if nursing visit only for allergy injections, injections such as insulin, heparin, and antibiotics, preventive adult and child immunizations)	17
Services provided by a hospital:		
• Inpatient	\$500	37
• Outpatient	\$150	38
Emergency benefits	\$100 outpatient hospital visit	41
• In-area	\$30 urgent care center	41
• Out-of-area	\$40 urgent care center	41
Mental health and substance abuse treatment:	Regular cost sharing	43
Prescription drugs	\$15 Generic (Preferred) drugs \$35 Brand (Preferred) drugs \$55 non-Brand (Non-preferred) drugs	47
Dental care	Limited benefit. Applicable physician visit copayment	49
Vision care	30% of all charges (materials) Applicable physician visit copayment (eye exam for children).	25
Special features: Flexible benefits option; Services for deaf and hearing impaired, pregnancies, Presbyterian Healthcare Services, vision, acupuncture, chiropractic, massage therapy, meals on wheels, fitness center, vision and hearing hardware discounts		50
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after \$2,000/Self Only or \$4,000/ Family enrollment per year Some costs do not count toward this protection	13

2009 Rate Information for - Presbyterian Health Plan

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

Postal rates apply to career Postal Service employees. Most employees should refer to the Guide to Benefits for Career United States Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to Postal Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	P21	\$155.66	\$107.77	\$337.26	\$233.51	\$179.45	\$83.98
High Option Self and Family	P22	\$352.56	\$245.73	\$763.88	\$532.42	\$406.42	\$191.87
Standard Option Self Only	P24	\$155.66	\$81.75	\$337.26	\$177.13	\$179.45	\$57.96
Standard Option Self and Family	P25	\$352.56	\$186.60	\$763.88	\$404.30	\$406.42	\$132.74